

THE DEVELOPMENT AND IMPLEMENTATION OF STATE OFFICES OF MINORITY
HEALTH

by
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ABSTRACT

BACKGROUND: Despite significant improvements in life expectancy and quality of life over the past century, health among some racial and ethnic populations in the United States continues to lag behind others. In response to these disparities, states have sought ways to use the legislative process to address health disparities, including establishing state Offices of Minority Health (OMHs). Most states have an OMH or related entity; yet, little is known about how these offices were developed or implemented.

METHODS: A systematic review of proposed and enacted legislation from 2002-2011 targeting racial and ethnic health disparities was conducted to understand how states have used legislation to address health disparities. State bills were identified using a standardized search protocol in LexisNexis State Capital, and coded on several domains. A comparative case study was conducted to determine how two OMHs (Maryland and Florida) were developed and implemented. Fifteen in-depth key informant interviews were conducted with OMH leadership, staff, community partners, and legislators and a document review was conducted; both the interviews and documents were analyzed thematically.

FINDINGS: Forty-five states introduced at least one bill specifically targeting racial and ethnic health disparities, and 607 bills were analyzed. Of these 607 bills, 330 passed into law (54.4%). These bills approached eliminating racial and ethnic health disparities through governmental infrastructure, providing appropriations, and focusing on specific diseases, among others.

Case study results illustrated several factors influencing the development or implementation of state OMHS, including political will and policy entrepreneurship, the role of policy understanding, the importance of developing community leadership, capacity, and sustainability of health disparities programs, and the role of community, academic, and legislative partnerships and relationships.

CONCLUSION: Legislation is an important policy tool for states to advance the elimination of racial and ethnic health disparities. Additionally, case study results show the roles state OMHS have played in advancing efforts to eliminate racial and ethnic health disparities, and also provide a foundation for future evaluations of state OMHS. State legislation has the potential to address racial and ethnic health disparities, such as through policies targeting the public health workforce, specific racial and ethnic groups, data collection and state OMHS.

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LIST OF DEFINITIONS AND ABBREVIATIONS

The following are definitions of various terms as they are used throughout this study.

Health disparities: In this study, health disparities refer to both health care and health status disparities. This term is also used as encompassing differences in health outcomes among different groups of racial and ethnic populations that are avoidable, unnecessary, and unjust (Braveman, 2014; Braveman, 2006). This definition of health disparities represents the more recent usage of the term among both federal and state governments.

Health disparities policies: Health disparities policies will be identified in this study as those policies specifically identifying the goals of improving minority health or eliminating racial and ethnic health disparities in the statutory language.

Office of Minority Health: The term Office of Minority Health (OMH) will be used to describe all organizational entities (i.e., Office of Minority Health and Health Disparities, Office of Health Equity, Office of Multicultural Health, etc.) at the state government level whose mission and responsibility is to achieve health equality or health equity and eliminate health disparities.

MD MHHD: This refers to the Maryland Office of Minority Health and Health Disparities, the state agency responsible for improving minority health and eliminating health disparities in Maryland.

FL OMH: This term refers to the Florida Office of Minority Health, the state agency responsible for improving minority health and eliminating health disparities in Florida.

Racial and ethnic minority populations: These populations are typically defined as non-White populations (i.e., African American/Black, Hispanic, etc.) (Bhopal, 2004). For the purpose of this study, minority populations will not be specifically defined by the researcher. The definition of racial and ethnic minority populations will be purposefully vague to allow for themes and meanings of minority populations to emerge from the perspectives of interview participants and as described in documents related to OMH development and implementation.

MOTA: This refers to Minority Outreach and Technical Assistance, the primary grant-making model of the MD MHHD.

CTG: This acronym refers to the Closing the Gap grant-making model of the FL OMH.

CHAPTER 1

INTRODUCTION AND BACKGROUND

BACKGROUND

Racial and Ethnic Health Disparities

Too many Americans in some racial and ethnic groups are unable to reach the full potential of their health, despite recent progress in overall health outcomes. Even after decades of documenting racial and ethnic health disparities, striking differences in health outcomes remain. Some racial and ethnic populations, especially African Americans/Blacks and American Indians/Alaskan Natives, are more likely to die prematurely, suffer from chronic diseases such as diabetes, obesity, and cardiovascular disease, and to have unmet healthcare needs (Keppel, 2007; Adler & Rehkopf, 2008).

Kitigawa and Hauser, in the first U.S. study with sufficient statistical power to determine racial differences in mortality, found that the all-cause age-adjusted mortality for non-Whites was 34% higher for males and 20% higher for females (1973). Current research shows that these data have not significantly improved since the 1970s, which was when this study was published. Research shows that the Black-White mortality gap for some groups (i.e., men) has widened since the 1960s, even though some social determinants of health (i.e., high school dropout rates) have improved for some racial and ethnic groups (Satcher, Fryer, McCann, Troutman, Woolf, & Rust, 2005). Recent time trend analyses also show that while some disparities have narrowed, some racial and ethnic groups lag behind others in other health outcomes. Bleich, Jarlenski, Bell, & LaVeist found a

decrease in the gap of life expectancy, but an increase in other health outcomes, such as infant mortality and diabetes between 1980 and the mid-2000s (2012).

Racial and ethnic health disparities are important to understand and eliminate due to the economic and social costs these disparities impose, combined with changing U.S. demographics. As the populations of Hispanic, Black, and other non-Hispanic and non-White racial and ethnic groups continue to grow (U.S. Census, 2012), improving the health of these racial and ethnic groups is a priority to policymakers, researchers, and public health advocates. These racial and ethnic disparities in health outcomes are not only unfair and unjust, but are also costly. Scholars at the Joint Center for Political and Economic Studies estimated that between 2003 and 2006, health disparities were responsible for 30% of direct medical care expenditures, and the combination of health disparities and premature death cost \$1.24 trillion (LaVeist, Gaskin, & Richard, 2009). If health disparities were eliminated, indirect costs due to health disparities would have decreased by more than \$1 trillion between 2003 and 2006 (LaVeist et al., 2009). The economic and social costs may be difficult for the U.S. to bear as the non-White racial and ethnic populations continue to grow and age without marked improvement to their health.

The 1985 publication of the *Heckler Report* exposing the persistence and significance of racial and ethnic health disparities in the U.S. in the post-Civil Rights era prompted national attention to find ways to eliminate health disparities. The *Secretary's Task Force Report on Black and Minority Health*, initiated in 1984 by then Secretary of the U.S.

Department of Health and Human Services Margaret Heckler, is a 10-volume report detailing excess deaths among some racial and ethnic populations compared to non-Hispanic Whites. One of the main findings from the *Heckler Report* was that there were 60,000 excess deaths per year in minority populations, and six causes of deaths accounted for more than 80% of these excess deaths (cancer, cardiovascular disease, chemical dependency, homicide/suicide/unintentional injuries, diabetes, and infant mortality) (Centers for Disease Control and Prevention, 1986). The *Heckler Report* also outlined eight main recommendations to address these disparities, including racially and ethnically targeted education campaigns, improving data quality and availability, and supporting research to examine factors impacting minority health, among others (Centers for Disease Control and Prevention, 1986).

Causes of Racial and Ethnic Health Disparities

The determinants of racial and ethnic health disparities are complex and varied. Biological, behavioral, environmental, social, and structural factors are the main categories of the determinants of health disparities documented by researchers. Biological determinants of health disparities focus on biological risk factors; genetic predisposition is one such factor. Researchers have given attention to genetic determinants of disparities in outcomes for some diseases, particularly diabetes, hypertension, asthma, low birth weight, obesity, and prostate cancer, among others (Cooper, 2004). Theories on biological determinants of health disparities posit that some populations have higher

genetically based risks for certain diseases, thus leading to group differences in health outcomes. Other biological determinants include age and sex.

Health behaviors, such as tobacco and excessive alcohol use, physical activity, and diet, are often cited as factors in determining health disparities. Studies using national data show that compared to non-Hispanic Whites, Blacks are less likely to be physically active and eat fewer fruits and vegetables, and are more likely to be current smokers and obese (King, Mainous, Carnemolla, & Everett, 2009). Other disparities in health behaviors include vaccination rates, risky sexual practices, prenatal care, and illegal drug use (Alexander, Kogan, & Nabukera, 2002; Hallfors, Iritani, Miller, & Bauer, 2007).

More recent studies show that social conditions, which can influence health behaviors, are strong determinants of health disparities. Social determinants of health are generally understood to be the non-medical factors of health outcomes, such as income, education, housing, transportation, environment, and social organizations or hierarchies (i.e., segregation, racism, etc.). The World Health Organization (WHO) defines the social determinants of health as, “the conditions in which people are born, grow, live, work, and age,” such as schools, neighborhoods, and working environments, among others (World Health Organization, n.d.). Both the epidemiology and determinants of racial and ethnic health disparities are further explored in chapter 2.

State Approaches to Eliminating Racial and Ethnic Health Disparities

Following the publication of the *Heckler Report*, many states have used its legislative powers towards eliminating these racial and ethnic differences in health outcomes. Researchers have also continued to recommend a number of policies to achieve health equality in the U.S. A few studies have focused solely on providing policy recommendations states could take towards eliminating racial and ethnic health disparities, such as the collection of policy recommendations by McDonough (2004). These recommendations focus on improving racial and ethnic health data collection at the state and local levels, evaluation of statewide health and community-based disparities programs, increasing diversity in the statewide health care workforce, and improving access to and quality of health care throughout the state. Despite the widespread focus on state policies to eliminate health disparities, analyses of state health disparities policy development and implementation is lacking in the literature.

STUDY PURPOSE AND OVERVIEW

The purpose of this study is to identify and characterize state legislation addressing racial and ethnic health disparities introduced throughout the U.S. between 2002 and 2011. Previous research has shown that a common legislative approach to eliminate racial and ethnic health disparities was the creation of state Offices of Minority Health (OMHs) (Ladenheim and Groman, 2006). Although OMHs have been a key policy strategy used by states to address health disparities, to date, there have been no reports in the peer-reviewed literature of the development and implementation of state OMHs. As such,

another purpose of this study is to understand the development and implementation of state OMHs from the perspectives of those involved in Office development and implementation. This study is guided by three aims related to state health disparities legislation and OMH development and implementation. These aims are first presented on page 46.

Results from this study fill gaps in the literature concerning health disparities policymaking and implementation in the U.S. in at least two ways. First, state legislatures are important arenas for advancing public policy aimed at eliminating racial and ethnic health disparities. The current literature on health disparities policies has primarily offered policy recommendations without looking at the subsequent steps in the policy process – formulation and implementation. Second, only a single study in the peer reviewed literature to date has examined health disparity policies in the U.S. While the study generated important findings, the data are from over a decade ago (Ladenheim & Groman, 2006). Given that research on racial and ethnic health disparities has grown substantially since the early 2000s, a current analysis of health disparity policies is warranted, which this study aims to fill.

Results also provide information related to state policymaking processes to achieve local, state, and national health equity goals such as those outlined in *Healthy People 2020*. Study findings illustrate the role of the state legislature and factors key to successfully using the state legislature towards eliminating racial and ethnic health disparities, as well as some challenges and impacts of implementing state OMHs. Finally, study results set a

foundation for future research on health disparities policymaking and implementation, including research on diversifying the public health workforce and the health impacts of state OMHs.

DISSERTATION OUTLINE

Chapter 2 presents a synthesis of the literature on racial and ethnic health disparities, policy development, and policy implementation. Chapter 3 presents the methods for the study, including the study aims and research questions and methods for those aims. Study results are presented in Chapter 4. The dissertation concludes with Chapter 5, which presents a discussion on the study results, policy implications, future areas of research, and study strengths and limitations.

CHAPTER 2

LITERATURE REVIEW

This chapter reviews the literature related to health disparities and health equity. The chapter begins with a brief examination of data and research on racial and ethnic disparities in health, illustrating historical and current trends in racial and ethnic health disparities and the mechanisms shaping those disparities. Next, is a discussion of various approaches to eliminating racial and ethnic health disparities, including programmatic and policy-oriented strategies states have used, such as Offices of Minority Health (OMHs), followed by a discussion of public health policy development and implementation. Because public policy is a common tool used towards addressing racial and ethnic health disparities, an overview of policy development and implementation literature will follow. The chapter ends with the gaps in the literature on health disparities policy development and implementation.

RACIAL AND ETHNIC HEALTH DISPARITIES: DEFINITIONS, MEASUREMENTS, DATA, AND DETERMINANTS

Defining Racial and Ethnic Health Disparities

Despite significant improvements in life expectancy and quality of life over the past century, health among some populations in the U.S. remains a paradox. Racial and ethnic health disparities in the U.S. are well documented. Health disparities typically refer to those differences in health outcomes between different groups and do not necessarily

carry moral imperatives (Braveman, 2006). The term “health inequalities” is becoming increasingly popular among public health researchers and practitioners. This term refers to health differences between groups of people based on race and ethnicity, positions in the socioeconomic hierarchy, and gender (Braveman, 2006). This is a more generic term describing variations in health outcomes between different groups and, similar to health disparities, this term does not have normative judgments.

The term “health inequities” is more common outside the U.S. than health disparities, particularly in the United Kingdom and other European countries. Health inequities are defined as health inequalities that result from injustice and are unfair (Kawachi, Subramanian, & Almeida-Filho, 2002). Whitehead and Dahlgren expand upon this definition by adding that these inequities are avoidable and unnecessary (2007).

Braveman notes that there is little consensus about the meanings of these terms (2006); however, these terms are important because they have policy implications, including what is measured as part of surveillance, resource allocation, and policy strategies devoted to achieving equal health outcomes (Braveman, Murray, Starfield, & Geiger, 2001). These terms have different theoretical bases, which should also be noted. For example, the idea of health inequities implicitly includes moral considerations and acknowledges the role of social imbalances in health outcomes; however, the term “health disparities” only implies a difference in health outcomes and does not carry a moral imperative.

There is also debate as to when a difference in health outcomes becomes a disparity.

Hebert and colleagues examined this debate, noting that how a disparity is conceptualized determines how large, if any at all, a disparity is when measured (Hebert, Sisk, & Howell, 2008). The authors also note that definitions of disparities impact what is understood to be the underlying causes, and, thus, the appropriate interventions to address those disparities (Hebert et al., 2008).

Definitions of health disparities, inequity, and inequality have evolved since the beginning of the health disparities movement. The definition changes reflect both the evolving understanding of health disparities and politics. For example, at the World Health Organization (WHO), equity in health in the late 1990s was focused on “minimizing avoidable disparities in health and its determinants...between groups of people who have different levels of underlying social advantage or privilege” (Braveman, 1998). Between 1998 and 2003, researchers at WHO expanded that definition to state that health inequalities should be defined, “as any avoidable differences in health between any individuals, who should not be grouped a priori according to social characteristics, except possibly geographic location” (Braveman, 2006).

Historically, American scholars defined health disparities without consideration of the health equity concepts or frameworks that dominated European definitions. Although terms such as “health inequities” have recently begun to appear at the U.S. federal level, the term “health disparities” remains the dominant term in political discourse. While there are various types of health disparities, such as by gender, geography, sexual

orientation, intellectual and developmental disabilities, age, education, and socioeconomic status (SES), racial and ethnic health disparities will be the focus here due to the significant attention these disparities have been given at all levels of government in the U.S.

Use of Race and Ethnicity in Public Health

Public health scholars commonly use race and ethnicity in their research. An estimated 65-80% of published studies included in literature reviews published through the early 2000s used race or ethnicity as a variable (Ahdieh & Hahn, 1996; Comstock, Castillo, & Lindsay, 2004; Jones, LaVeist, & Lillie-Blanton, 1991). In these studies, race and ethnicity were used for different purposes, such as stratification, identification of different risk factors, and as a proxy for SES variables (Jones, 2000; Williams, 1994). Despite this usage, researchers often fail to differentiate between race and ethnicity, using these terms synonymously or interchangeably (Comstock et al., 2004).

Researchers throughout public health and social sciences more broadly have acknowledged the lack of conceptual precision of race and ethnicity (LaVeist, 1994; Williams, Lavizzo-Mourey, & Warren, 1994). Despite the lack of uniform definitions of these terms, race and ethnicity are generally acknowledged in research as two distinct constructs. Race is commonly used to describe a social classification based on different phenotypes, such as skin color and other physical attributes, and are often attributed to a particular geographic region (i.e., Africa, Caucasus, Asia, etc.). Ethnicity, as used in

public health and social science research, tends to refer to culture, such as shared language and ancestry (Ford & Kelly, 2005).

Research provides evidence that those labeled as a certain race (White, Black, etc.) have a mixture of genes from various parts of the world (Jones, 2001). There is also evidence that methods to measure race and ethnicity is imprecise to make significant claims about genetic liabilities, and increasing numbers of “mixed-race” populations due to immigration and interracial partnerships makes the use of race and ethnicity in research difficult (Mays, Ponce, Washington, & Cochran, 2003).

While there is some evidence of linkages between race and ethnic categories and a few diseases (i.e., sickle cell) (Mays, Ponce, Washington, & Cochran, 2003), the biological basis of race is generally not used in current public health and social science research. As such, researchers tend to favor the social construction of race. Another aspect of race and ethnicity to note is that the conceptualization and definitions of race and ethnicity have changed over time, providing more evidence of the social construction of race. Due to the complexities and evolution of defining race and ethnicity, some researchers have called for the elimination of the use of race and ethnicity in public health research (Buehler, 1999; Fullilove, 1998). Advocates of this approach argue that discontinuing the use of these concepts in public health research and practice could lead to an increased use of social determinants of health to explain differences in health outcomes (Mays et al., 2003)

The conceptual use of race and ethnicity in public health is important to note because it informs how racial and ethnic health disparities are measured and analyzed. Ultimately, the actions taken towards eliminating racial and ethnic health disparities, including resource allocation and programmatic and policy decisions, are shaped by how race and ethnicity are conceptualized. Throughout this study, race is defined as a social construct based on various phenotypes and markers, as is common in public health research (Warren, Hahn, Bristow, & Yu, 1994).

Currently, the U.S. Office of Management and Budget (OMB) standardized race into five categories: White, Black or African American, American Indian or Alaskan Native, Asian, and Native Hawaiian or other Pacific Islander. The OMB also includes one ethnicity group (Hispanic/non-Hispanic origin) (Office of Management and Budget, n.d.). According to U.S. Census data, the following racial and ethnic groups represent about 31% of the U.S. population: Black or African American, American Indian or Alaskan Native, Asian, Native Hawaiian or other Pacific Islander, and Hispanic (i.e., together these groups are often considered racial and ethnic minorities) (U.S. Census, 2012). These categories set forth a minimum standard of reporting race and ethnicity throughout federal agencies and for those participating in federal programs. Although standardized, these categories are broad and do not account for variability within each racial and ethnic group, which could result in missed information, miscategorization, and poor understanding of these populations (Allen, Lachance, Rios-Ellis, & Kaphingst, 2011; Comstock et al., 2004). For example, among Asians, researchers found that different ethnic groups classified themselves in a multitude of ways. For example, in one study,

Filipinos self-identified as Asian, other Pacific Islander, White, or Spanish (Holup, Press, Vollmer, Harris, Vogt, & Chen, 2007). In order for data on race and ethnicity to be useful, these classifications must reflect the population groups the data intend to capture, as well as account for how those responding to the racial and ethnic questions see themselves.

Collecting and Measuring Racial and Ethnic Health Disparities

Scholars and researchers agree that health disparities indicate health differences between population groups; however, there is some disagreement as to how to measure those differences and what those differences ultimately mean. Additionally, there is relatively little known about the validity and reliability of self-reported race and ethnicity, health outcomes, and its related determinants (Stewart & Nápoles-Springer, 2003).

Large, national community-based surveys are a common approach to conducting health disparities surveillance. One example is the Racial and Ethnic Approaches to Community Health across the U.S. (REACH U.S.) Risk Factor Survey conducted annually across selected communities with large populations of racial and ethnic minorities by the Centers for Disease Control and Prevention (Liao et al., 2011). Similarly, the national Behavioral Risk Factor Surveillance System (BRFSS) and National Health and Nutrition Examination Survey (NHANES) capture health outcomes by race and ethnicity and have been used to track racial and ethnic health disparities over the past few decades (Centers for Disease Control & Prevention, 2004; Kenik, Jean-Jacques, & Feinglass, 2014; Liss &

Baker, 2014; White, Pollack, Smith, Thompson, Underwood, & Fairley, 2013). Other methods of documenting racial and ethnic health disparities include local, community-based health assessments (Ahmed & Palermo, 2010). Compared to national data, these assessments not only allow for data to be collected at smaller geographic units, such as beyond zip codes, which may capture what the communities consider to be their neighborhoods rather than predefined boundaries. Such health assessments may also provide opportunities for community involvement in data collection and health disparities research.

There are challenges to collecting data on racial and ethnic health disparities. While there is some standardization in racial and ethnic categorization, as previously mentioned, this standardization only applies to federal agencies and those programs receiving federal funds. Thus, organizations outside of the federal system that have significant healthcare data, such as health plans and private hospitals, may have racial and ethnic data that is not comparable to the federal data. This difference in data collection creates barriers to fully understanding racial and ethnic health care disparities, including factors related to health disparities and trends over time (Bierman, Lurie, Collins, & Eisenberg, 2002; National Research Council, 2004; Hasnain-Wynia & Baker, 2006). Increasing the use and dissemination of data on race and ethnicity from private insurance plans and hospitals raises some concerns. For example, patient privacy, legal constraints on when and how patient racial and ethnic data can be collected within the healthcare system, and political concerns may hinder attempts to increase the use of healthcare data in health disparities research (Hasnain-Wynia & Baker, 2006).

Despite these data collection challenges, once health data are collected by race and ethnicity, there are multiple approaches to measuring health disparities. Using a comparative approach is common in racial and ethnic health disparities research. This approach focuses on comparing the health data of one racial or ethnic group to another population group, which tends to be the White population. A within-group approach would explore differences in health outcomes within a population group; for example, comparing subgroups within the Asian population rather than comparing Asians to another population.

The comparative approach, according to some researchers, may be problematic when attempting to identify where and how to intervene. For example, Bediako and Griffith argue that using comparative frameworks in racial and ethnic health disparities research may deemphasize health promotion within racial and ethnic minority groups (2012). The authors continue to advocate for a within-group approach, which could decrease disparities by emphasizing tailored, culturally relevant public health interventions (Bediako & Griffith, 2012).

Differentiating Between Health and Health Care Disparities

Many researchers synonymously use health disparities and health care disparities when discussing differences in health outcomes. While related, health disparities and health care disparities are distinct concepts. Health care disparities tend to focus on those

determinants related to the health care delivery system, such as access to care, cultural competency, patient-provider interactions, and quality of care. The Institutes of Medicine report, *Unequal Treatment: Confronting Racial/Ethnic Disparities in Health Care*, is a landmark report highlighting nearly 200 studies detailing racial and ethnic differences in medical diagnosis and treatment, health insurance status, disease stage or progression, source of care, quality of care, and service delivery and is a prime example of research focusing on health care disparities (Institutes of Medicine, 2003). Health disparities tend to focus on differences in health outcomes and determinants of these disparities beyond health care. For example, health disparities would include differences in health outcomes such as chronic and infectious diseases (i.e., diabetes, obesity, cardiovascular disease, and cancer), health behaviors (i.e., smoking, physical activity, and diet), and overall health status (i.e., self-rated health and life expectancy).

Epidemiology of Racial and Ethnic Health Disparities in the U.S.¹

W.E.B. Du Bois wrote one of the earliest documentations of the racial differences in health in 1906 entitled *The Health and Physique of the Negro American*, noting that these differences were due to environmental factors, such as poverty and insanitary conditions, rather than inherent biological racial differences. However, the 1985 *Heckler Report* can be seen as a conversation starter for the modern era of health disparities discourse (Thomas, Benjamin, Almario, & Lathan, 2006). The *Secretary's Task Force Report on Black and Minority Health (Heckler Report)* is a 10-volume report detailing excess

¹ Throughout this chapter, the nomenclature used to describe the various racial and ethnic populations will be presented as they were used in the original studies.

deaths among some racial and ethnic populations compared to Whites initiated in 1984 by then Secretary of the U.S. Department of Health and Human Services Margaret Heckler. One of the main findings was that there were 60,000 excess deaths per year in minority populations, and six causes of deaths accounted for more than 80% of the excess deaths (cancer, cardiovascular disease, chemical dependency, homicide/suicide/unintentional injuries, diabetes, and infant mortality) (Centers for Disease Control and Prevention, 1986).

Racial and ethnic health disparities in health outcomes have persisted for decades. Some racial and ethnic populations, especially African Americans/Blacks and American Indians/Alaskan Natives, are more likely to die prematurely, suffer from chronic diseases such as diabetes, obesity, and cardiovascular disease, and to have unmet healthcare needs (Adler & Rehkopf, 2008; Keppel, 2007). Kitigawa and Hauser, in the first U.S. study with sufficient statistical power to determine racial differences in mortality, found that the all-cause age-adjusted mortality for non-Whites was 34% higher for males and 20% higher for females (1973). Current research shows that these data have not improved since the 1970s, which was when this study was published. Research shows that the Black-White mortality gap for some groups (i.e., infants and men) has widened since the 1960s, even though some social determinants of health (i.e., high school dropout rates) have improved (Satcher et al., 2005). Recent time trend analyses also show that while some disparities have narrowed, some racial and ethnic groups lag behind others in other health outcomes. For example Bleich et al. found a decrease in the gap of life expectancy

between Black and White Americans, but an increase in other health outcomes, such as infant mortality and diabetes between 1980 and the mid-2000s (2012).

Some racial and ethnic populations are more likely to suffer from chronic diseases. On average, Blacks and American Indians and Alaska Natives are twice as likely to be diagnosed with diabetes (Department of Health and Human Services, 2012a). Nonwhites are also more likely to be overweight and obese than Whites; American Indians and Alaskan Natives are 1.6 times as likely to be obese than Whites, and Black women are 80% more likely to be obese than non-Hispanic White women, for example (Department of Health and Human Services, 2012b). Blacks and other non-White racial and ethnic groups disproportionately suffer from HIV/AIDS, accounting for approximately 71% of newly diagnosed HIV cases in 2009 (Department of Health and Human Services, 2012c). Black men are about 10 times as likely as non-Hispanic White men to die from AIDS (Department of Health and Human Services 2012c). There is a plethora of data available demonstrating these, and more racial and ethnic health disparities, which are more fully explored elsewhere (LaVeist, 2005b).

These health disparities are also prevalent among youth and adolescents. Non-White and Hispanic children and young adults are more likely to live in neighborhoods with more environmental toxins, have higher rates of asthma and lead poisoning, and are more likely to be overweight or obese (Elster, Jarosik, VanGeest, & Fleming, 2003; Lieu et al., 2002). Research also shows the presence of health care disparities. For example, minority youth are less likely to have access to health services, such as having a primary

care medical home, mental health services, and dental care (Brousseau, Hoffmann, Yauck, Nattinger, & Flores, 2005; Elster, Jarosik, VanGeest, & Fleming, 2003; Raphael, Guadagnolo, Beal, & Giardino, 2009). Flores and Tomany-Korman, using data from the National Survey of Children's Health, found that while uninsured rates for White and African American children were comparable (6% and 7% respectively), 21% of Latino children and 15% of Native American children were uninsured (Flores & Tomany-Korman, 2008).

The authors also noted significant health disparities between children of specific racial and ethnic groups. Compared to White children, Flores and Tomany-Korman found higher rates of asthma, behavior problems, skin allergies, and speech problems among African American children. Latino children were more likely to have suboptimal health status, poor teeth condition, and unmet prescription needs. Native American children were more likely to have hearing or vision problems, no usual source of care, and unmet medical and dental needs. Asian and Pacific Islander children tended to have barriers to specialty care and were more likely to not have seen a doctor in the past years (Flores & Tomany-Korman, 2008). An updated study by Flores and Lin show no significant changes in health disparities since the publication of the Flores and Tomany-Korman study (Flores & Lin, 2013).

Researchers have also noted racial and ethnic disparities in exposure to risk factors for diseases and other health conditions among children. For example, Taveras and colleagues examined racial and ethnic differences in early-life risk factors associated with

childhood obesity. They found that Black and Hispanic children had higher ranges of risk factors for childhood obesity compared to White children, such as higher rates of maternal depression, higher intake of sugar-sweetened beverages, and higher intake of fast food (Taveras, Gillman, Kleinman, Rich-Edwards, & Rifas-Shiman, 2010). There are also racial and ethnic disparities in health behaviors among youth, such as physical activity, diet, binge drinking, and sexual behaviors (Gordon-Larsen, McMurray, & Popkin, 1999; Harris, Gordon-Larsen, Chantala, & Udry, 2006). Researchers have also noted disparities in environmental factors related to health, such as racial and ethnic residential segregation, fewer areas for physical activity or recreation in minority communities and higher exposure to food deserts and violence (Acevedo-Garcia, Osypuk, McArdle, & Williams, 2008; Penny Gordon-Larsen, Melissa C Nelson, Phil Page, & Barry M Popkin, 2006; H. M. Hill & Madhere, 1996; Stein, Jaycox, Kataoka, Rhodes, & Vestal, 2003).

Determinants of Health Disparities

The determinants of racial and ethnic health disparities are complex and controversial. Biological, behavioral, social, and structural factors are the main categories of the determinants of health disparities documented by researchers (Dressler, Oths, & Gravlee, 2005). Biological determinants of health disparities focus on biological risk factors, such as genetic predisposition. Researchers have given attention to genetic determinants of disparities in outcomes for some diseases, particularly diabetes, hypertension, asthma, low birth weight, obesity, and prostate cancer, among others (Cooper, 2004). Theories on

biological determinants of health disparities posit that some populations have higher genetically based risks for certain diseases, thus leading to group differences in health outcomes (Frank, 2007). However, as previously discussed, most researchers agree that race is a social, not genetic construct. Thus, the connection between genetics and racial and ethnic health disparities is not widely supported (Braun, 2002).

Health behaviors are often cited as important in determining health disparities. These health behaviors tend to include smoking, excessive alcohol use, physical inactivity, and diet. For example, studies using national data show that compared to non-Hispanic Whites, Blacks are less likely to be physically active and eat fewer fruits and vegetables, and are more likely to be current smokers and obese (King, Mainous III, Carnemolla, & Everett, 2009). Other disparities in health behaviors include routine screenings, vaccination rates, risky sexual practices, prenatal care, and illegal drug use (Alexander, Kogan, & Nabukera, 2002; Hallfors, Iritani, Miller, & Bauer, 2007; Kenik et al., 2014). Because health behaviors are correlated with health outcomes, recognizing racial and ethnic differences in health behaviors is one factor in understanding racial and ethnic health disparities.

Health literacy, defined as the ability to use health information from any type of source to make appropriate health decisions, can also influence health behaviors and in turn health disparities (Berkman, Sheridan, Donahue, Halpern, & Crotty, 2011; DeWalt, Berkman, Sheridan, Lohr, & Pignone, 2004). Language, one aspect of health literacy, has been cited as a factor in racial and ethnic health disparities. For example, those with limited English

proficiency were more likely to have difficulties with medical comprehension, such as trouble understanding labels or understanding a medical situation, than English-proficient patients (Wilson, Chen, Grumbach, Wang, & Fernandez, 2005). This language incongruence impacts the quality of care limited patients who speak little to no English receive, even with health insurance, and can result in underuse of healthcare services and adverse health outcomes (Brach, Fraser, & Paez, 2005; Fiscella, Franks, Doescher, & Saver, 2002; Pippins, Alegría, & Haas, 2007).

Health behaviors occur in various social environments. More recent studies show that social conditions, which can influence health behaviors, are strong determinants of health disparities. Social determinants of health are generally understood to be the non-medical factors of health outcomes, such as income, education, housing, transportation, and social organizations or hierarchies (i.e., segregation, racism, etc.). The WHO defines the social determinants of health as, “the conditions in which people are born, grow, live, work, and age,” such as schools, neighborhoods, and working environments, among others (World Health Organization, 2012). LaVeist and colleagues documented the significance of social environments on racial and ethnic health disparities as a part of the Exploring Health Disparities in Integrated Communities (EHDIC) study. This study was designed to examine the role of race, SES, and segregation as confounders of health disparities data (LaVeist et al., 2008). Using data from a low-income and racially integrated community in Southwest Baltimore, the authors found a narrowing or elimination of racial and ethnic health disparities often found in national data, such as obesity among women, diabetes, and hypertension (LaVeist, Pollack, Thorpe Jr, Fesahazion, & Gaskin, 2011). Because

these data represent racially and ethnically diverse populations living with the same environmental and social risks, these results highlight the importance of systemic and structural determinants of health, such as community resources and SES.

Researchers have also examined the relationship between SES and racial and ethnic health disparities. SES is commonly comprised of several indicators as proxies for class (income (both individual and average neighborhood income), education, occupation, and wealth) due to the lack of a general definition of class in the U.S. Additionally, it has been difficult to disentangle racial and ethnic health disparities from SES, prompting researchers to ask if these disparities are due to race, class, or the combination of race and class (Kawachi, Daniels, & Robinson, 2005). Race and ethnicity and SES have separate influences on health disparities, but also influence health disparities in combination. For example, one study found that for males aged 18 and younger, Blacks were more likely to have an elevated blood level compared to non-Hispanic Whites, and among Blacks, those with a lower SES were more likely to have an elevated blood level compared to Blacks with a higher SES (LaVeist, 2005a).

There are several structural determinants of health disparities to note. One of the most discussed and visible determinant is healthcare, including access and quality. Researchers have found that some racial and ethnic groups report low rates of health care utilization, poor quality of care, and are more likely to be uninsured (Ashton et al., 2003; Fiscella et al., 2002; Shi, 2000). The U.S. has a long history of discrimination in healthcare and other forms of medical injustice (Thomson, 1997). This discrimination ranges from *de*

jure denial of providing healthcare to racial and ethnic minority populations to individual acts of discrimination by healthcare providers. Geographic isolation of quality healthcare facilities prevented many racial and ethnic minorities from being able to access needed healthcare.

Individual characteristics within the healthcare setting may also contribute to racial and ethnic health disparities. Providers, for example, may have limited skills in cross-cultural communication, implicit biases and stereotypes about minority racial and ethnic populations, all of which impact the quality and level of care patients receive and health outcomes (Burgess, Fu, & Van Ryn, 2004; Smedley, Stith, & Nelson, 2009; Van Ryn, 2002).

Research on the role of neighborhoods and health outcomes, while mixed, has illustrated various connections between neighborhood characteristics and racial and ethnic health disparities. Diez Roux and colleagues have examined the relationships between geographic and spatial differences in neighborhoods, health behaviors, and health outcomes (Diez Roux, 2001; Diez Roux & Mair, 2010). Pearl, Braveman, and Abrams, using birth records linked to Census block-group data found an association between neighborhood condition and lower birthweight among Blacks and Asians, but a less consistent relationship for Whites, US-born Latinas, or foreign-born Latinas (2001). Ko and colleagues found that among White, Black, Cuban, and non-Cuban Latino older adults, neighborhood characteristics such as the proportion of older adults, the proportion of individuals below poverty, and the proportion of residents from the same racial and

ethnic groups in the Census block, self-rated health was similar (2014). The researchers found that race or ethnicity did not impact self-rated health; those living in poorer neighborhoods regardless of race or ethnicity were more likely to have lower self-rated health outcomes (Ko, Jang, Park, Rhew, & Chiriboga, 2014).

Neighborhoods may influence health behaviors and health outcomes due to various factors. One aspect of neighborhoods and community environment that may influence health disparities is the role of racism and discrimination. These issues have been given significant attention in health disparities research due to the racial history of the U.S., and the impact of race on the structure of society both historically and currently. Williams, among others, has written extensively on this topic (Williams & Collins, 2001; LaVeist, 1993). Racial segregation, resulting from historical practices of legal racial discrimination in housing, is linked with racial health disparities. A consequence of the legacy of segregation is that middle-income Blacks are more likely to live in poorer areas, whereas poor Whites are more likely to live in mixed-income areas (Williams & Jackson, 2005). Areas with a high proportion of minority residents are also more likely to have poor access to resources linked to health, including quality health care, fresh foods, and safe and attractive public recreation areas, and are more likely to be exposed to health-compromising factors, such as pollution and environmental toxins, fast food and liquor stores, and crime (Boer, Pastor Jr, Sadd, & Snyder, 1997; Bower, Thorpe Jr, Rohde, & Gaskin, 2014; Gordon-Larsen, Nelson, Page, & Popkin, 2006; Larson, Story, & Nelson, 2009; LaVeist & Wallace Jr, 2000; Pais, Crowder, & Downey, 2014; Powell, Slater, & Chaloupka, 2004; Ross & Mirowsky, 2001).

Overt discrimination, as observed by U.S. housing practices and patterns, is not the only racism-related pathway tied to health disparities. Subjective measures of racism, such as perceptions of racism, are also correlated to poorer health outcomes experienced by minorities. In a meta-analysis examining potential pathways through which perceived discrimination impacts health, Pascoe and Smart Richman found that perceived discrimination is significantly associated with poorer health outcomes, including mental and physical health (2009). Related to discrimination, perceived stereotype has also been identified as a potential determinant of racial and ethnic health disparities. Perceived or overt, racial discrimination in healthcare and the broader social environment has been and continues to be significantly related to racial and ethnic health disparities in the U.S. (Paradies, Truong, & Priest, 2014; Williams & Mohammed, 2009).

Other Health Disparities-Related Research

In addition to understanding the extent of racial and ethnic health disparities and related determinants, health disparities research explores other topics. Racial and ethnic minority participation in public health research, including medical studies and experiments, is one such topic. Some researchers found no difference in the rates of participation in medical research between racial and ethnic minorities and non-Hispanic Whites (Katz et al., 2007; Wendler et al., 2005). Research has also identified factors underlying racial and ethnic minority participation or non-participation in medical research, including historical factors related to medical research among minority populations and building trust among

minority communities (George, Duran, & Norris, 2014; Katz et al., 2007; Yancey, Ortega, & Kumanyika, 2006).

Another topic seen as influencing health disparities is the role of racial and ethnic diversity within the public health and healthcare workforce. Currently, the public health workforce lacks racial and ethnic diversity, meaning that while minority public health professionals are more likely to work in medically underserved areas, many racial and ethnic minority communities tend to be served by public health professionals that do not look like them or share a similar culture (LaVeist & Pierre, 2014; Phillips & Malone, 2014). While increasing racial and ethnic diversity in the public health workforce is one approach towards mitigating the effects of the current lack of diversity (Marrast, Zallman, Woolhandler, Bor, & McCormick, 2014; Popper-Giveon, Liberman, & Keshet, 2014), increasing and improving cultural competency among the current public health workforce is an approach focused on by advocates and researchers (Betancourt, Green, Carrillo, & Park, 2005; Cohen, Gabriel, & Terrell, 2002).

The framing of health disparities language and public perception of the extent and causes of racial and ethnic health disparities, are also viewed as important for racial and ethnic health disparities. For example, Niederdeppe and colleagues examined the framing of racial and ethnic health disparities in the mass media, and found that although media coverage of these health disparities is increasing, there is a limited framing of racial and ethnic health disparities in the media messages (Niederdeppe, Bigman, Gonzales, & Gollust, 2013). Other researchers have focused on the impacts of the framing of racial

and ethnic health disparities, such as message resistance and the role of political ideologies in accepting health disparities messages (Gollust & Cappella, 2014) and the views of journalists and others with power to shape messages in the mass media on health disparities, its causes, and how related messages should be framed (Wallington, Blake, Taylor-Clark, & Viswanath, 2010).

CURRENT HEALTH DISPARITIES POLICIES, PROGRAMS, AND INITIATIVES

Advocates, scholars, and practitioners have developed and implemented various health disparities approaches based on the determinants of racial and ethnic health disparities at the federal, state, and local levels. These approaches have built on historical health disparities efforts and include strategic planning, programmatic, and policy strategies. Although there were key events prior to the 1985 *Heckler Report* such as the National Negro Health Week and the Office of Negro Health Works (Thomas, Benjamin, Almarino, & Lathan, 2006), the impetus for more recent federal and state action can be traced to this report. As mentioned above, this report provided data on disparities in health outcomes, and also outlined eight main recommendations to address these disparities. These included racially and ethnically targeted education campaigns, improving data quality and availability, and supporting research to examine factors impacting minority health, among others. This report resurrected a national focus on minority health and racial and ethnic health disparities, such as spurring the creation of OMHs at the federal and state level, beginning with Ohio in 1987 (Thomas et al., 2006). Efforts at the state level since this report have focused on creating legislation, programs, and other initiatives to

eliminate racial and ethnic health disparities (Ladenheim & Groman, 2006; McDonough, 2004).

Public health programs targeting these health disparities include general health disparities awareness and education programs, disease and population-focused programs, such as diabetes education programs targeting African Americans, and programs focused on the public health workforce, such as increasing workforce diversity and cultural and linguistic competency among public health professionals. Some state and local governments, under the Centers for Disease Control and Prevention Racial and Ethnic Approaches to Community Health (REACH) grant, have developed community-based programs to eliminate racial and ethnic health disparities. REACH grantees focus on diseases disproportionately impacting minority communities (cardiovascular disease, diabetes, obesity, among others), and have resulted in increased awareness of racial and ethnic health disparities, provided leadership focused on racial and ethnic health disparities, and advanced understanding of the drivers of these health disparities (Buckner-Brown et al., 2011; Liburd, Jack Jr., Williams, & Tucker, 2005).

State health departments and their stakeholders often create strategic plans with objectives to improve population health, which may include goals to decrease health disparities. For example, the State Health Improvement Process, the strategic public health plan for Maryland, includes public health measures to achieve, but also provides a focus on health disparities (Maryland Department of Health and Mental Hygiene, 2012). One approach to eliminating racial and ethnic health disparities is requiring state health departments to report racial and ethnic health data to the state legislature that could be used to inform state health goals. In addition to guiding state and local policymaking

efforts, improving health disparities data collection and reporting can lead to more targeted resource allocation and program design. Some planning efforts have also included attention to data collection and systematic tracking of health disparities data, such as conducting community health assessments.

Over the past several decades, states have used their legislative and other policymaking processes towards eliminating racial and ethnic health disparities. Ladenheim and Groman published the first study to outline states' legislative approaches to address health disparities in health and health care and identified the creation of offices of minority health (OMH) as the most common legislative response states have taken in this area (2006). Other policy approaches include programmatic efforts targeting organizations at various levels, such as the state public health agency, hospitals, and institutions of higher education (Ladenheim & Groman, 2006). Programmatic approaches based in policies mandating education and outreach activities include targeting specific racial and ethnic groups, directing various groups to conduct research studies and collect data, providing grant-making opportunities, and health care and clinician-based interventions, among others (McDonough, 2004). State policies can also include mandates for strategic planning to address racial and ethnic health disparities, direct program implementation, and require minority health surveillance and monitoring.

POLICY DEVELOPMENT AND IMPLEMENTATION

A classic definition of public policy is proffered by Dye; he defines public policy as “anything a government chooses to do or not to do” (Dye, 1998, pg. 2). A more elaborate definition of public policy is provided by Jenkins, defining public policy as “a set of interrelated decisions taken by a political actor or group of actors concerning the selection of goals and the means of achieving them” (Jenkins, 1978, pg. 15). Public policies set the framework in which interventions are to be implemented.

Policy Development

A common adage in politics is that policymaking is like sausage making, meaning that making public policy is often messy and unrecognizable results because the outputs may significantly differ from the inputs. Due to the messiness of policymaking, there are numerous theories in the literature attempting to demonstrate and explain the policymaking process. Although a central theory of policymaking is lacking in the literature, these models are useful in exposing multiple points of influence in the policymaking process. Policies are determined by several factors, including values, research and data, public opinion, and political pressure, among other determinants.

Policymaking theories began with stages and agenda-setting models, implying that policymaking occurred rationally and linearly. John Kingdon’s Multiple Streams model is one such framework that was applied to this research (2003). This theory posits that policy is the outcome of the combination of three streams: problems, policy, and political streams. The problem stream is composed of various social issues policymakers hope to

address, which tend to be defined through their values and beliefs about the problem. The policy stream includes a mixture of ideas that are put forth to address the problem. The final stream, politics, is composed of the national mood, interest or advocacy group campaigns, and administrative and legislative changes. These streams, when combined with each other, a policy entrepreneur, and a policy window or opportunity to act, result in a desired policy output (Kingdon, 2003; Mintrom, 1997; Zahariadis, 2007).

These rational and linear models evolved to illustrate feedback processes, such as the Advocacy Coalition Framework (ACF). ACF models policy development through the relationships of different coalitions of actors, each tied together by a particular set of values and ideas about a policy problem and approaches to addressing that problem. Within the model are relatively stable parameters, the policy subsystem, and external events that could influence the parameters and the policy subsystem. (Weible, Sabatier, & McQueen, 2009). This theory of policymaking also includes aspects of coalitions, such as their beliefs towards a policy problem and resources available to promote their position (Sabatier & Weible, 2007). Researchers using this model are also concerned with how advocacy coalitions are mobilized and maintained (Weible, Sabatier, Jenkins-Smith, Nohrstedt, Henry, & deLeon, 2011).

The policy process is not as rational or linear as policy theory models propose. However, there are common aspects of the policy process that these models highlight. For example, policy is driven by a problem, or a perception of a problem. These problems may be influenced by external environmental conditions, some of which remain relatively stable

over time, and include as demographics, economics, social changes, or a focusing event. Political leadership and political will are also shared aspects across policy models. Ultimately, policymaking is defined by power (Stone, 1997). Individuals, such as the policy entrepreneurs described by Kingdon, must have enough power within a governing body to set and drive a legislative agenda, and to garner enough voting support to pass proposed legislation (Kingdon, 2003).

States wield significant policymaking power given the federalist nature of the U.S. government and use this power to address a wide array of policy problems. States are often referred to as laboratories for public policies, particularly in the policy innovation and diffusion literature (Gray, 1973). Policymaking at the state level differs for each state for various reasons, including state demographic makeup and institutional structures (i.e., legislative professionalism and term limits), among others. Despite these differences, some states take similar approaches to policy problems due to policy diffusion and policy learning (Berry, 1994). Because of this, it is important to analyze how states approach policy problems, including problem identification and construction, framing and discourse, the development and selection of policy alternatives, and policy implementation.

Framing and Discourse in Policy Development

Policymaking and policy implementation are social acts requiring meaning-generating and sense-making processes, including interpreting discourse. Discourse is a “patterned system of texts, messages, talk, dialogue or conversation,” identifiable through oral and

textual communication (Lupton, 1992). It is important to examine discourse during the policy development and implementation processes. Discourse is a means of communicating ideas, which are influenced by worldviews and cognition. Discourse is also a way of creating and maintaining hierarchies of power; because discourse produces and represents ideas and knowledge, discourse also dictates how ideas are discussed, thought about, and acted upon (Foucault, 1980; Hall, 2001). These factors impact how policies are developed and implemented.

Recognizing this, some scholars have applied discourse analysis to public health research. Researchers have examined the social construction of public health policies and media coverage of health disparities. For example, Kim, Kumanyika, Shive, Igweatu, & Kim examined the framing of causes and solutions of health disparities in U.S. newspapers between 1996 and 2005 (2010). They concluded that the media framed health disparities as a result of differences in health behaviors and suggested that this discourse may limit policy approaches to eliminate health disparities due to the role of media in influencing public opinion (Kim et al., 2010).

Framing is important in the policymaking process because it affects how and if an issue can be seen as a social problem requiring a social solution, and if it is put on the political agenda. Framing the issue occurs throughout the policymaking process. According to Deborah Stone, “problem definition is a process of image making, where the images have to do fundamentally with attributing cause, blame, and responsibility” (1989). This process requires policymakers and other interested parties to portray, or frame, an issue in

a way to gain support for their arguments (Stone, 1989). One aspect of framing includes the generation and dissemination of causal stories, which are ideas of the mechanisms causing social issues. Policymakers use causal stories to assign responsibility and to influence ideas used to guide policy. Stone argues that causal stories are useful in generating political will to eliminate racial and ethnic health disparities (Stone, 2006). Another aspect of framing includes the construction of a target population, which refers to the normative and evaluative characterizations assigned to different population groups whose behaviors and well-being are impacted by public policy (Schneider & Ingram, 1993). However, the use of causal stories, and the framing of health disparities during policy development and implementation more generally, have not been fully examined in the peer-reviewed literature.

Policy Implementation

Policymaking does not end with the signing and enactment of a bill; the policymaking process continues throughout policy implementation. Policy implementation has several definitions, but is basically the process by which governments enact policies (Howlett, 2011). This process is significant to examine due to its effect on policy outcomes and effectiveness. Policy implementation studies explore how policies have been interpreted outside of the legislative process, thus giving insight on the meanings of public policies (Yanow, 1996).

Pressman and Wildavsky are credited with setting the foundations of policy implementation research as a discipline with the publication of Implementation: how

great expectations in Washington are dashed in Oakland: or, why it's amazing that federal programs work at all, this being a saga of the Economic Development Administration as told by two sympathetic observers who seek to build morals on a foundation of ruined hopes (1984). However, implementation research began at least four decades prior to Implementation, but Pressman and Wildavsky's book stimulated new interest in the topic (Saetren, 2005).

Similar to policymaking, there is no single, centralizing theory of policy implementation. Approaches to policy implementation research can generally be grouped as: top-downers, bottom-uppers, and synthesizers (Hill & Hupe, 2002). Top-downer researchers, beginning with Pressman and Wildavsky, posit that policies contain goals and the methods of achieving those stated goals from the policymaking arena that are provided to implementers (Pressman & Wildavsky, 1984). Daniel Mazmanian and Paul Sabatier sophisticated the top-down implementation framework by introducing a feedback process, which included asking how policies were reformulated over time based on the implementation experience and examining how the actions of implementers were consistent with the policy decision (Hill & Hupe, 2002).

Bottom-up implementation research focuses on the implementers, or "street-level bureaucrats." Michael Lipsky set the stage for understanding how policymaking continues even after a policy is passed; he writes, "...the decisions of street-level bureaucrats, the routines they establish, and the devices they invent to cope with uncertainties and work pressures, effectively become the public policies they carry out"

(2010, pg.xiii). Other scholars argue that the political process continues through implementation, where policy intentions are interpreted and modified according to the implementers' worldviews and assumptions (Hill & Hupe, 2002).

Synthesizers promoted policy implementation theories that bridged both top-down and bottom-up perspectives, and includes some scholars whose views evolved to synthesize the various views of policy implementation. In the early 1990s, Sabatier, for example, moved towards a model of policy implementation combining aspects of top-down and bottom-up policy implementation perspectives, such as the role of policy learning and experiences of policy implementers (Schofield, 2001).

Although policy implementation research reached its height in the 1980s, the field resurged in the early 2000s. This literature, while further advancing implementation research and theories from previous decades, also emphasizes the importance of maintaining focus on implementation in policy and public administration research. For example, Schofield argues that a current research agenda focused on policy implementation is warranted and that the field should embrace both perspectives of political science and public services management to advance implementation research (2001). Other researchers have shared this view, arguing that policy implementation research is experiencing a revival, and that future research should focus on both theory development and efforts to scientifically synthesize research findings (Saetren, 2005).

Factors in Policy Implementation

Results from previous implementation research not only include the development of implementation theories, but also the identification of factors driving policy implementation. These factors include those that facilitate and hinder successful policy implementation. Research has generally identified these key factors as policy awareness and understanding, capacity, funding and other resources, and support.

Low policy awareness limits policy implementation by resulting in little efforts towards implementing a policy. Related to awareness is how implementers understand a problem, make sense of the policy designed to address that problem, and how that understanding is created (Yanow, 1993). Cognition among implementers includes understanding the meaning and intent behind a policy and the process of creating that meaning. Similar to some theories of policymaking, this aspect of policy implementation also includes implementers' values, beliefs, attitudes, and previous experiences (Spillane, Reiser, & Reimer, 2002). There is a growing body of research examining the role of cognition, interpretation, and policy understanding in policy implementation, particularly in education (Coburn, 2006; Spillane, Reiser, & Reimer, 2002).

Capacity refers to the ability of implementers to carry out implementation activities, such as the skills and understanding needed to implement the policy's mandates. This also concerns the ability of the implementing agency to mobilize the capacities available within the organization (McLaughlin, 1987). Policy implementation often requires funding, which can impact how agencies implement policies; however, some policies or

mandates are underfunded or completely unfunded, leaving implementers with fewer financial resources needed to fully implement the policy. Other resources, such as time, are also needed to implement public policies. All implementing agencies operate in an environment of limited resources; however, the levels of resources available to agencies within and across locales may vary and impact implementation at various degrees.

Support for policy implementation includes administrative and political support, such as will and buy-in at all levels of the public sector. Increased administrative or political support is associated with improved implementation both theoretically and empirically (McLaughlin, 1987; Sabatier & Mazmanian, 1980). The institutional setting in which implementation occurs can factor into this support, such as the number of layers required in decisions-making and the nature of the authority leaders and subordinates have related to carrying out policy implementation (Hill & Hupe, 2002).

The majority of early implementation research lacked clear policy recommendations to improve policy implementation (O'Toole, 1986); however, some researchers have provided collections of various factors necessary for successful implementation related to policy development. For example, Mazmanian and Sabatier offer a set of six sufficient conditions of effective implementation, which include a strong enabling legislation or mandate, proper jurisdiction for carrying out policy mandates, and the existence of strong managerial and political skill among leaders of the implementing agency, among others (Mazmanian & Sabatier, 1983; Sabatier & Mazmanian, 1978).

Other researchers have attributed poor policy implementation to inadequate policy design and argue that increased policy clarity can lead to improved implementation (Hogwood & Gunn, 1984; Matland, 1995). Other researchers argue that well-designed policies are necessary, but not sufficient, for policy implementation and achieving desired policy outcomes (May, 1991). However, most researchers acknowledge that there is a connection between policy design during the development stage and subsequent policy implementation (Howlett, 2011).

Relationships between Policy Development and Implementation

Policymakers have several policy tools at their disposal to address policy problems. These tools include regulation, loans, purchasing, direct provision of services, and education, among others. An analysis of policy tools can lead to a greater understanding of public policy. Previous researchers have focused on analysis related to the, “creative process of designing solutions to public policy problems” and have noted that an exploration into policy design could provide improved insight into the policymaking process (Linder & Peters, 1984, pg. 237).

Although scholars have been interested in the tools of government for centuries, the policy instrument and policy design literature started to peak in the late 1980s and early 1990s. In some sense, this literature is experiencing a revival, as scholars seek to understand policy choice particularly in an age where research and knowledge can change rapidly. For example, a 2007 issue of *Governance* focused on the analysis of

public policy change using a policy instruments framework. In this sense, a policy tool, or policy instrument is, “a device that is both technical and social, that organizes specific social relations between the state and those it is addressed to, according to the representations and the meanings it carries” (Lascoumes & Le Gales, 2007, pg. 4).

POLICY DEVELOPMENT AND IMPLEMENTATION RESEARCH IN PUBLIC HEALTH

Many public health professionals, including researchers and advocates, recognize the importance of understanding and being involved in the policy process. As Thomas Oliver writes, “Politics, for better or worse, plays a critical role in health affairs” (Oliver, 2006, pg. 195). As such, the politics behind health issues should be examined and understood, particularly when working to achieve health equality. Health is an inherently political policy domain, and political science and policy studies concepts and theories have been used in public health research. The majority of previous policy research in public health focuses on policy evaluation rather than the policy process itself, including policy development and design. Researchers have called for greater inclusion of public policy and political science theories to explain the health policy process and to improve advocacy and evaluation efforts (Bernier & Clavier, 2011).

The observed trend of a lack of research focused on public health policy processes might be reversing. A recent article in the American Journal of Public Health examining the policy instruments states have used related to the school food environment is one of the few public health studies using this approach (Shroff, Jones, Frongillo, & Howlett, 2012).

Another article published in 2012 analyzed state statutes providing legal authority to state health departments for injury prevention (Stier, Thombley, Kohn, & Jesada, 2012).

Overall, these studies only describe the policies and do not examine their development or implementation.

As these studies show, there is increasing interest in implementation research within the public health literature. This body of evidence, however, does not tend to include a political science framework when examining implementation. A lack of such a framework can miss important information about the factors influencing the implementation of public health policies. Rather, dissemination and implementation research within public health generally focuses on the implementation of evidence-based policies, programs, and interventions (Aarons, Hurlburt, & Horwitz, 2011; Rabin, Brownson, Haire-Joshu, Kreuter, & Weaver, 2008; Wandersman et al., 2008). This implementation literature is concerned mainly with bridging the gap between science and practice, rather than legislative policy and practice. Other public health implementation research focuses on implementation outcomes instead of the process of implementation itself (Proctor et al., 2011).

Although policy development research is lacking in public health, health policies are one of the most frequently policy areas studied in implementation research (Saetren, 2005).

For example, researchers have looked at the implementation of gun laws to prevent injuries and violence (Frattaroli & Teret, 2006) or the implementation of a Texas bill aimed to increase physical activity in elementary schools passed in 2001 (Kelder et al.,

2009). Despite these inquiries, few studies in the public health policy development and implementation research literature focus specifically on health disparities.

Health Disparities Policy Development and Implementation Research

The Multiple Streams and ACF policymaking models have been applied to public health and health disparities policymaking (Trivedi, Gibbs, Nsiah-Jefferson, Ayanian, & Prothrow-Stith, 2005). Some authors have used these frameworks to examine and evaluate health disparities and minority health programs, particularly those that are local or community-based. Some of the implementation research on health disparities program aims to translate evidence into practice and policies (Fleming et al., 2008; Glasgow, Klesges, Dzewaltowski, Bull, & Estabrooks, 2004). A common approach used in the studies to evaluate health disparities interventions is the RE-AIM (Reach, Effectiveness, Adoption, Implementation, and Maintenance) framework (Gaglio, Shoup, & Glasgow, 2013). RE-AIM includes aspects of evaluating the implementation of programs, but tends to not include a political science or public administration perspective in those evaluations. This absence may be because researchers tend to use the RE-AIM framework to evaluate health outcomes and impacts, rather than solely on implementation processes (Jilcott, Ammerman, Sommers, & Glasgow, 2007). Additionally, the majority of research applies the RE-AIM framework to health disparities programs. However, some researchers have applied this framework towards policies, and encourage the use of this framework to estimate public health impacts and

for public policy planning and evaluation (Jilcott, Ammerman, Sommers, & Glasgow, 2007).

SUMMARY

There is an extensive literature on racial and ethnic health disparities; however, this literature has predominantly documented the extent and determinants of the disparities, presented results from interventions designed to reduce and eliminate racial and ethnic health disparities, and discussed programmatic and policy strategies to address these disparities. Existing peer-review research has not assessed the development and implementation of these health disparities policies, particularly from a political science or public administration framework.

Given the current state of knowledge, a gap remains in the literature in understanding how policy strategies states have chosen to take to eliminate racial and ethnic health disparities have been developed and implemented. The purpose of this study is to address the gaps in the literature on state health disparities policy development and implementation by examining recent trends in state legislation targeting racial and ethnic health disparities, and how one common state policy strategy, the creation of state OMHs, was developed and implemented in two states. The methods for this study will be discussed in the following chapter.

CHAPTER THREE

METHODS

This chapter begins with a presentation of the study aims and research questions, followed by a discussion of the conceptual model driving this study. The conceptual model is described in the context of the literature summarized in the previous chapter. The chapter concludes with a discussion of the methods used for each of the three aims and related research questions.

STUDY AIMS AND RESEARCH QUESTIONS

This study has three aims and eight research questions related to health disparities legislation, and the development and implementation of two state offices of minority health.

Aim 1: Identify and typify proposed and enacted state legislation to eliminate racial and ethnic health disparities from 2002-2011.

Research questions:

1.1 What are the policy tools states have relied upon in the legislative process in attempts to eliminate racial and ethnic health disparities?

1.2 What are the variations in the legislative patterns chosen by states?

Aim 2: Understand perspectives of policymakers, state health officials, and other key stakeholders regarding the *development* of state Offices of Minority Health.

Research Questions:

- 2.1 What is the current discourse on racial and ethnic health disparities in state legislatures (i.e., issue framing) and how has that discourse evolved since the *Heckler Report*?
- 2.2 What is the perceived impact of a state's previous legislative approaches to eliminate racial and ethnic health disparities on subsequent policies and programs?
- 2.3 Who are the main actors in health disparities legislative policy development and what are their beliefs and roles?

Aim 3: Understand perspectives of policymakers, state health officials, and other key stakeholders regarding the *implementation and perceived impact* of state Offices of Minority Health.

Research Questions:

- 3.1 How have state OMHs been implemented and who is responsible for implementation?
- 3.2 What are the similarities and differences in OMH implementation between states?
- 3.3 What are the perceived impacts of state OMHs?

CONCEPTUAL MODEL

A conceptual model adapting the Advocacy Coalition Framework (ACF) and Multiple Streams model (Figure 1) guides this study, particularly Aims 2 and 3. Both frameworks have been applied to several policy domains, including energy, environmental, and education policy, among others.² The ACF was first published in the late 1980s by Paul Sabatier and Hank Jenkins-Smith and has undergone several revisions since the initial publication. The model assumes that there are some relatively stable parameters (i.e., resource distribution and the attributes of the problem area), events external to the policy subsystem (i.e., changes in public opinion and socioeconomic conditions), short-term constraints and resources of subsystem actors, long term coalition opportunity factors (i.e., degree of consensus needed for major policy change and openness of the political system), and the policy subsystem (Weible et al., 2011; Weible, Sabatier, & McQueen, 2009). The policy subsystem has mechanisms internal to the system, such as the beliefs, resources, and strategies of different coalitions, decisions by government authorities, and policy outputs and impacts. These elements are relevant to this study because the development and implementation of OMHs are subject to these factors and are necessary to address the three aims and research questions.

² See, e.g., Mintrom M, Vergari S. Advocacy coalitions, policy entrepreneurs, and policy change. *Policy Studies Journal*. 1996;24(3):420-434. (ACF and education policy); Nohrstedt D. The politics of crisis policymaking: Chernobyl and Swedish nuclear energy policy. 2008;36(2):257-278. (ACF and energy policy); Huitema D, Meijerink S. Realizing water transitions: the role of policy entrepreneurs in water policy change. *Ecology and Society*. 2010;15(2):26. (Multiple Streams and environmental policy).

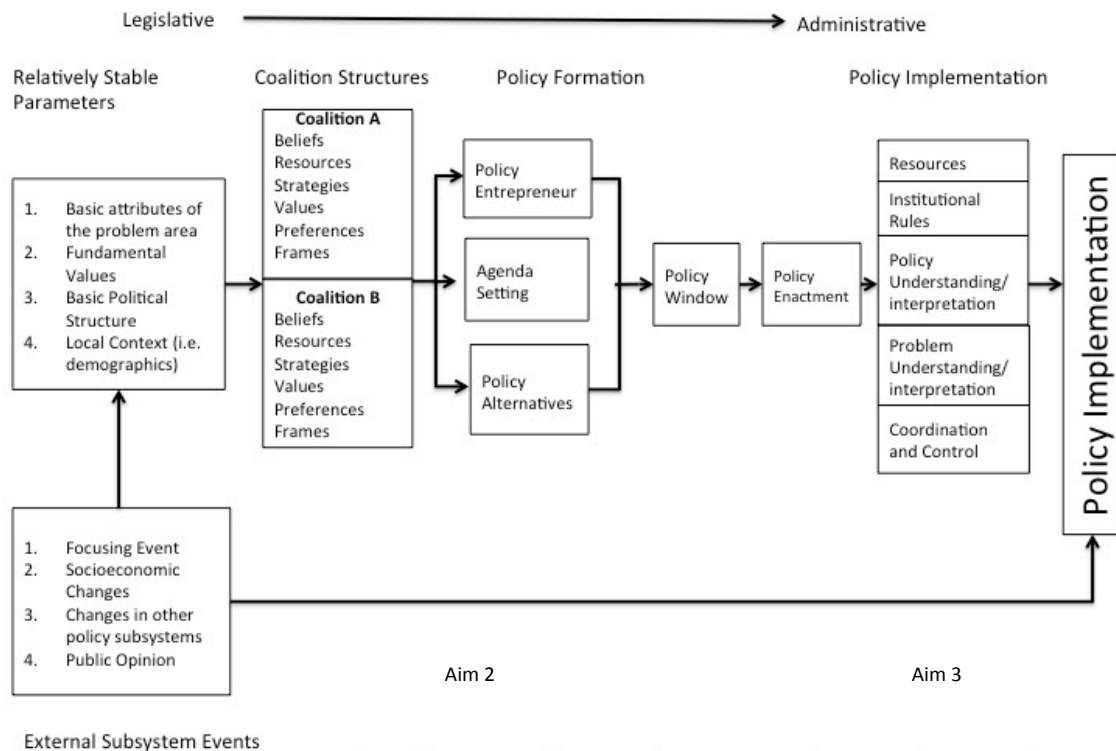
In John Kingdon's Multiple Streams model, three streams lead to policy development: the problem, policy, and political streams (Kingdon, 2003). These streams come together, with the efforts of policy entrepreneurs, to create a policy window whereby policies can be pushed forward onto the policy agenda. In the problem stream, political actors frame conditions as a problem, gaining attention to a particular issue using science, focusing events, and other sources of information that are interpreted as problematic. The policy stream is often referred to as a "soup" of various ideas generated by experts; while there are many ideas in this mix, only a select few achieve prominence. The politics stream includes the national mood, interest groups, and administrative and legislative turnover. Policy entrepreneurs are political actors working to join the three streams together who are not only skilled in advocacy, but are also power brokers and are able to act when political opportunities arise (Zahariadis, 2007).

There are several salient points of this model applicable to the health disparities policymaking process. For example, this model focuses on multiple actors from different aspects of the policy subsystem, attention to the role of beliefs in the policy cycle, the recognition of the influence of events external to the policy subsystem, the role of ideas in the policy process, and the appreciation of policy entrepreneurs in policy development. These factors are especially important for policies focused on sensitive and value-laden subjects, such as policies targeting race and racial and ethnic inequalities. Additionally, health disparities are influenced by a multitude of factors ranging from individual, community, economic, and social factors; thus, addressing health disparities through policymaking requires multiple actors.

One weakness of both of these models is that they describe the policy process, but omit factors that influence policy implementation. Therefore, these models were further modified for this research to include determinants of policy implementation as identified in the literature.³ Public policies may include directives designating the resources provided for implementation (funding, infrastructure, etc.), create the institutional rules in which implementation must occur, and designate the institutions responsible for implementation. Implementation is also influenced by how implementers interpret the policy, as well as their own understanding of the problem and appropriate solutions.

³ See, e.g., Grin J, Graaf Hvd. Implementation as Communicative Action: An Interpretive Understanding of Interactions between Policy Actors and Target Groups. *Policy sciences*. 1996;29(4):291-319.; Matland RE. Synthesizing the implementation literature: The ambiguity-conflict model of policy implementation. *Journal of public administration research and theory*. 1995;5(2):145-174.; Schofield J. Time for a revival? Public policy implementation: a review of the literature and an agenda for future research. *International Journal of Management Reviews*. 2001;3(3):245-263.

Figure 1: Conceptual Model



Adapted from Weible CM, Sabatier PA, Jenkins-Smith HC, et al. 2011 and Kingdon J. 2002.

The conceptual model in Figure 1 aided in the conceptualization and development of the study design, and approaches to Aims 2 and 3. Aim 2 (policy development) corresponds to the Coalition Structures and Policy Formation phases of the conceptual model. Aim 3 (policy implementation) relates to the Policy Implementation phase of the model and reflects a bottom-up or “street-level bureaucrat” understanding of policy implementation. The research questions developed for each of the study aims were guided by its related aspect in the conceptual model. For example, research question 2.1 directly corresponds to the frames used by each coalition, as shown in the Coalition Structures phase of the

model. Further, the components of the conceptual model guided the design and selection of interview questions and provided the initial themes for data analysis.

STUDY METHODS

Aim 1

Aim 1 utilized legal mapping of states' proposed and enacted legislation related to racial and ethnic health disparities from 2002-2011 to address the research aim and questions. Legal mapping is a research method to analyze the legal environment either currently or over time of laws for a particular public health topic (Burris et al., 2013). Legal mapping studies provide information about the prevalence and distribution of specific types of laws; thus, given the objective of Aim 1, this was the most appropriate method to address the study aims.

This research began with 2002 because previous research on this topic explored legislation through the first 18 months of the 2001-2002 state legislative session (Ladenheim & Groman, 2006). The study period concluded with 2011 because at the time of data collection, 2011 was the most recent year available with complete legislative data. Proposed and enacted legislation was analyzed in this study, including state bills that were introduced and failed, and those that were introduced and ultimately became law. Data collection and analysis methods are further described below.

Keyword Development and Data Collection

To identify applicable proposed and enacted legislation, a systematic and structured keyword search of proposed and enacted health disparities bills at the state level during January 1, 2002- December 31, 2011 was employed. LexisNexis State Capital (LexisNexis, 2014), an online database of state bills and statutes, was used to collect relevant bills from all 50 U.S. states specifically addressing racial and ethnic health disparities utilizing a set of standardized keywords.

An iterative process was used to identify keywords. Thirteen keywords were initially selected based on the keywords from the Ladenheim and Groman study. To validate these keywords, I used LexisNexis to identify the laws in their study results. These keywords yielded 41 verifications out of 81 (51%) laws listed in the Results section in the Ladenheim and Groman study. Additional keywords were generated by “reverse engineering”; that is, looking at the full text of the remaining bills and statutes not verified by the initial keywords from the Ladenheim and Groman study to determine what keywords would provide their results. This method was a result of consulting with a public health law researcher experienced in public health law research methods. Thirty-eight of the remaining laws were found using information provided in Ladenheim and Groman’s article, such as statute or bill number and year. Three bills or statutes were not immediately located, possibly because of redesignation or renumbering of the code since the study was conducted. After further examining the 3 remaining laws, I determined that

some information about those statutes in the Ladenheim and Groman study was incomplete, such as missing portions of a statute's number. The missing information appeared to be the reason why those laws were not identified initially by looking at the legal citation using those keywords.

To recap, the keywords used for this research identified the statutes included in Ladenheim and Groman study, but a few were listed in the study as a different statute; thus, the statutes found using the keywords did not immediately directly match up with those listed in the Ladenheim and Groman study. The keywords were verified by looking at the actual text of the law rather than just statute citation. This method of keyword generation yielded 12 additional keywords.

Potential keywords were also identified using current health disparities research literature. This allowed for the identification of language used to describe health disparities that may have been recently introduced or increased in usage since the publication of the Ladenheim and Groman study, such as the trend towards favoring "health equity" over "health disparities." These keywords were identified using listed keywords included within the peer-reviewed literature, such as those included under the abstract. Five additional keywords were identified using this method.

In total, 30 keywords were identified for the LexisNexis search (Appendix A). These terms were used with proximity searching methods, such as with "w/s" (within sentence), which searched for words within the same sentence. The truncation symbol (!) was also

used to search for multiple variations of a word. Minorit!, for example, searched for “minority” and “minorities.”

Some of the racial and ethnic health disparities literature focuses on Medicaid; however, bills related to Medicaid were not included in data collection or analysis. These bills were excluded because Medicaid, while designed to reduce health disparities among low-income populations and, by proxy, racial and ethnic minorities, is inherently a federal program that states can modify. Thus, since the focus of this study is on state-based initiatives towards eliminating racial and ethnic health disparities, Medicaid-focused bills fell outside the scope of this study.

Data Categorization

State bills were mainly categorized based on the topic areas addressed within the bill and using Microsoft Excel 2013. The keyword search yielded 2,560 bills. Out of those, 1,651 bills were cut due to not meeting the inclusion criteria, such as specificity on addressing racial and ethnic health disparities. A total of n=909 bills were identified for inclusion for research. When the search process identified multiple versions of a bill, this was noted and the most recent version was included in the study. The final dataset included n=607 bills. The number of bills decreased due to deleting multiple versions of bills (n=302).

Each bill in the final data set was downloaded and stored in an electronic file. As a validity check, the data set was compared to a publically available collection of state

health disparities bills (proposed and enacted) from the National Conference of State Legislatures (NCSL). This collection by NCSL included proposed legislation from 2010-2011 (National Conference of State Legislatures, 2014a), as well as state health disparities laws since 2005 (National Conference of State Legislatures, 2014b). Health disparities bills and laws in this collection related to health disparities data collection, health care and public health workforce, studies, infrastructure and task forces, Medicaid, and recognition of racial and ethnic health disparities, among others.

To make valid comparisons, only those bills that passed and became legislation between 2005 and 2011, and those bills that were introduced in 2010 and 2011 were compared to the NCSL databases. For example, in this study, 240 health disparities bills were identified as becoming legislation between 2005 and 2011, but the NCSL database included 190 different pieces of legislation. For 2010 and 2011, 51 and 61 different bills were identified for inclusion in this study respectively; however, the NCSL database included 50 for 2010 and 42 bills in 2011. For these instances where a discrepancy was noted the text of a bill or law was further examined to determine if different keywords were used, if the subject of a bill in the NCSL collection was out of the scope of this study (i.e., bills focused on health disparities other than racial and ethnic health disparities, Medicaid bills, or those bills that passed after 2011), or if the subject of a bill in this study's data collection was outside of the scope of the NCSL collection (i.e., bills on appropriations).

Each bill was read and coded on several dimensions, including topical, Census-based population variables, and political characteristics (Table 1). These codes were selected based on categorizations of health disparities policies in previous literature including categorizations used in the Ladenheim and Groman study, and factors that could influence state policy decisions, such as state demographics. For example, several coding categories were borrowed from the Ladenheim and Groman study, including disease-related; race-specific; infrastructure; and awareness. Some topic codes were expansions of categories used by Ladenheim and Groman, such as data collection/planning/reporting and workforce. Topical coding was not mutually exclusive. Legislative bills tend to address multiple policy domains, and coding was conducted in a manner to reflect this.

A bill was coded as falling under a specific characterization if language in the bill text indicated a presence of that characterization. For example, if a bill focused on one particular disease as identified through the language in the bill text, the bill was coded as a “1” under the “Disease-Specific” variable or as a “0” if there was no mention of the specific factor. These codes are defined in a codebook, located in Appendix B. Other bill characteristics, such as bill sponsor and related notes describing some bill details, were systematically captured. Bill sponsor was identified from the name listed as the bill sponsor on the bill. If no bill sponsor was explicitly named, then the name of the first legislator listed was used. Bill details were extracted from the LexisNexis summary of the bill.

Data Analysis

Data analysis included state characteristics, such as state demographic characteristics as identified from Census data, political factors, and the legislative year in which the bill was introduced. Data were analyzed by state, year, and geographic region (Northeast, South, Midwest, and West) and subregion (New England, Middle Atlantic, South Atlantic, East North Central, West North Central, East South Central, West South Central, Pacific, and Mountain) as determined by the 2010 U.S. Census Bureau.

Population demographics were also collected from the U.S. Census, including racial and ethnic population percentages (aggregated into two groups: non-White non-Hispanic minority population and non-White Hispanic population), and median income for each state. Census data were collected for each of the years of bills included in this study (2002-2011) and were also averaged across the time period to smooth out and account for any short-term fluctuations over time.

Political factors that were analyzed include bills introduced in Democratically-controlled legislatures and under Democratically-controlled governorships. This information was calculated using data from the Council of State Governments' *Book of States*, which provides annual data on the composition of state legislatures and governorships across all 56 U.S. states and territories. Data collected from the Council covered the time period from 2002 to 2011 (Council of State Governments).

Collected bills were analyzed by year and across years to explore trends and patterns. For both cross-sectional and longitudinal analysis, bills were analyzed for trends in introduced legislation by topic, state, geographic region, passage rates, minority population, and median household income.

Bills were compared using descriptive statistics. Frequencies were used to count the total number of bills by category, state, and year. Means and percentages were also used to analyze bills by category, state, and year. Some of these descriptive statistics were analyzed visually, such as using maps to demonstrate geographical variability in the number of bills introduced and number of categories addressed.

Table 1: Bill Coding Variables⁴

Legislative session (year)
Lead sponsor (sponsor's last name)
Pass status (y/n)
TOPIC AREAS
Appropriations (y/n)
Disease-specific (y/n)
Data collection/reporting/planning (y/n)
Cultural Competency (y/n)
Infrastructure (y/n)
Offices of Minority Health (y/n)
Task force/committee (y/n)
Representation (y/n)
Race-specific (y/n)
Recognition/Awareness (y/n)
Research study (y/n)
Workforce (y/n)

⁴ Some bills targeting chronic diseases were not included in this category because these bills, such as those targeting cardiovascular disease and obesity, tended to address more than one chronic disease within the bill.

Nonwhite, non-Hispanic population (percentage)
Hispanic population (percentage)
State median income (\$)
Number of Democratically controlled years in the state legislature, 2002-2011 (count)
Number of years of Democratic governor, 2002-2011 (count)

Aims 2 and 3

Study Design

Qualitative study designs are appropriate for studying the development and implementation of state health disparities policies for several reasons, particularly due to the interpretive nature of both policy development and implementation (Yin, 2009). It is widely accepted that political problems and associated public policies are social constructions and that the policymaking process is a social activity. Accepting that political problems are socially constructed requires a methodological approach enabling the analysis of social activities where multiple meanings are created, communicated, interpreted, and acted upon.

The comparative case study approach was used to gain insight into a phenomenon sharing a common theme within its respective context (Yin, 2009). Here, the phenomenon is the OMH and the contexts are the states in which these offices are located. Another reason the comparative case study approach was selected is the flexibility of the methods to capture the various differences in policy development and

implementation across space and time. Additionally, relatively little is known about health disparity policies and OMHs, making exploratory and descriptive methodological approaches appropriate to achieving the research aims of this study (Yin, 2009).

Theoretical Basis

The focus of this study is on the connection between “Policy Enactment” and “Policy Implementation” as shown in Figure 1, and the process that occurs for policy implementation. Taking an interpretive approach to understanding both policy enactment and policy implementation can fill important gaps in the public health policy literature. Interpretive policy analysis, as described by Yanow, “focuses on the meanings of policies, on the values, feelings, and/or beliefs which they express, and on the processes by which those meanings are communicated to and ‘read’ by various audiences.” (1996, p.8-9) For example, developing and ultimately implementing public policies requires sense- or meaning-making processes and can be viewed as “communicative interaction” between policymakers and policy implementers (Grin & Graaf, 1996). Implementers may interpret policies in multiple ways and may differ from the policymaker’s intent (Yanow, 1993). As such, interpretive approaches are useful in helping to understand public health policy development and implementation.

Case Selection

Potential cases were identified using the results of Aim 1. The focus of selecting case states to address Aims 2 and 3 was first on the mode of creation of the OMH. Because the aims and research questions focus on legislative policy development and implementation, the first selection criterion for case states was that the state OMH had to have been created through state legislation (18 states). These 18 states were identified from the legal analysis conducted for Aim 1, which identified the states that introduced and passed bills creating state OMHs. Data from the National Association of State Offices of Minority Health and the NCSL Health disparities database provided additional information related to the mode of creation for all state OMHs.

Another criterion considered for case states was the legislative context of the state. The legislative context included the number of health disparities bills introduced and the proportion passed during the study period. The number of topic areas contained in all of the introduced bills was also considered during the case selection process.

The state's political and demographic environments were also considered during case selection. Political and demographic data collected as a part of Aim 1 were used to compare states on several factors: the history of political partisan leadership in the state legislature and governor's office, economic environment (i.e., median income), and the proportion of minority and non-White Hispanic population during the study period.

In order to increase the generalizability of study results, variations in state demographic, economic, and political environments were purposefully sought. Selecting cases for

variation in these factors also allowed for the identification of similarities or differences in themes and the factors that may be associated with those findings (Yin, 2009). For example, states with varying levels of median income or different levels of racial and ethnic diversity were considered as case states.

Maryland was selected as the first case state. This selection was based on the year of the creation of the OMH, the state's economic profile, the political history of the state, and the composition of the minority population within the state. Additionally, the presence of what I perceived as a policy entrepreneur for health disparities policies within the state legislature was a factor in selecting MD as a case state. MD's office of Minority Health and Health Disparities (MHHD) was legislatively created in 2004, and was effective October 1, 2004.

Florida was selected as the second case state, based on the same variables that were considered when selecting MD. Like MD, the FL OMH was also legislatively created and became effective in 2004, and both states introduced legislation that covered all of the health disparities legislation topic areas. However, FL differs from MD in terms of political climate, economic conditions, and the composition of its racial and ethnic minority population. Further details on the backgrounds of both offices are presented in the Results (Chapter Four).

Data Collection

Two interview protocols were designed to conduct semi-structured key informant interviews (see Appendix C). One protocol was designed for use with OMH administrators and their agency partners, and the other for use with legislators.

Interview questions focused on the participant's experiences with OMH implementation, such as their perspectives of OMH successes, impacts, and challenges, policy development, and their perspectives on the nature of racial and ethnic health disparities and their causes. The interview guide for administrators and their agency partners address several points related to implementation from the conceptual model. For example, interview domains centered on resources available to the office for implementation, the process of implementation, perceptions of Office impact, and challenges to implementations, among others. The administrators and agency partners' instrument was pilot tested with three public health practitioners: one academic, one at the state level, and one at the federal level. Slight changes in the wording of a couple of the questions to improve clarity resulted from these pilot tests.

The instrument for legislators covered both office development and implementation. The instrument included domains related to framing racial and ethnic health disparities in the state legislature, reasons for introducing bills to create the office and other racial and ethnic health disparities bills, challenges the legislator encountered during the policymaking process, and their perceptions on office implementation and impacts. This instrument was pilot tested with one state level public health practitioner. As with the

other instrument, small changes in wording to improve clarity were made after this pilot test.

To be considered as a potential interviewee, the individual must have either worked at the OMH in MD or FL, partnered with the MD or FL office through formal partnerships such as through a grant, academic-community partnerships, service on an OMH-sponsored committee, or collaborated with the OMH in another significant way. Potential participants were initially identified using public information, such as an OMH organizational chart or public information about grantees and other partners. Four interviewees were identified through snowballing. Initial invitations to participate in an interview were sent to potential respondents via email (see Appendix D). Follow-up emails were sent to those who did not respond within three weeks to the initial email. After two non-responses, the potential participant was deemed as not interested in participation and no further contact was made. Non-respondents in FL included those currently working in the state OMH and some community partners. MD non-respondents included community partners from both rural and suburban areas of the state. Twelve potential participants were invited to an interview in MD, and 7 agreed to participate. Nineteen potential participants were invited to participate in an interview in FL and 8 agreed to participate.

After participants agreed to participate, a date and time was set for the interview. All participants provided informed oral consent before starting the interview (see Appendix E for the oral consent form). Fifteen semi-structured key informant interviews were

completed with 16 participants from both case sites (7 interviews for the Maryland case and 8 interviews for the Florida case). One interview (with representatives from Florida, so 9 interviewees) was conducted with two participants due to their schedules. Interviews were completed between December 2013 and July 2014. All interviews in Maryland were conducted in-person. Florida interviews were conducted via telephone. Interviews ranged from approximately 20 minutes to 1.25 hours, averaging 47 minutes. All interviews were professionally transcribed. I reviewed each transcript for errors, which were corrected when found. These errors were few and tended to be systematic, such as misspelling of acronyms or a missing word or two.

Interview participants included administrators (directors, assistant directors, program officers, grants manager, long-term consultants within the office, etc.) at the Florida and Maryland office, community partners such as grantees and academic partners, and one state legislator from each state. All Florida administrator participants were former administrators; current FL administrators were invited to interview, but after forwarding a request to participate to the FL Department of Health Office of Communication, no other updates were provided. While not a part of the inclusion criteria, all interviewees were involved with their respective office for at least two years. Additionally, all interviewees, except two, were female.

Relevant documents were systematically collected and reviewed across both case states to triangulate the interview data. These documents were systematically collected from each case state office's website. The first step was to visit the state's website and to visit

each page of the state office's website. The most current version of each document, linked from the homepage of the office's website, was downloaded as a PDF file and collected into folders indicating the page from which the document was downloaded. Once collected, these pages were systematically analyzed for relevant information, such as information on the office's background, current and former grants, publications, data, and events. The documents collected were limited to the time period provided by each state. For example, MD's website included documents from 2005, while the FL website was more recent (mostly from 2014, but the health profiles dated from 2008), probably because the FL website recently underwent a website redesign, and links to earlier reports and documents were missing or broken. Requests for updated links for these documents were made to the FL Department of Health. These requests were not completely fulfilled, meaning that the Office shared one requested document, but updated links were not provided.

Data Analysis

Interview data were coded thematically. Initial themes were derived from the conceptual model guiding this study (Figure 1). Additional themes emerged during each round of reading. Themes were then compiled into larger themes, consistent with Yin's model of explanation building (Yin, 2009). Using this method of analysis helped illustrate how the offices were implemented, and why participants' implementation experiences occurred as described. Coding was completed iteratively over a period of three rounds. Themes were analyzed within states and between states. This analytic approach was used to account for

differences in themes that could be influenced by the characteristics of the state, such as political, social, or economic environments. Themes were also analyzed by participant level (administrator, legislator, or partner) to explore possible differences in themes and examine if the position of the interviewee influenced how the themes were discussed. Collected documents were analyzed for information pertinent for understanding the background of each office, such as their purpose, mission, or vision, populations served, activities conducted, and other relevant information, such as documented results or impacts.

Protection of Human Subjects

This study posed minimal risk to study participants. Eligible participants included those directly involved in related OMH policy development and implementation, such as bill sponsors and OMH directors and staff. The burden to participants was their time to complete the interviews, which was described during the oral consent process. All data collected were kept confidential and care was taken to maintain the confidentiality of study participants throughout the project, including when quotes or statements were used. Participants did not receive payment for their participation and did not bear any direct costs. The Johns Hopkins Bloomberg School of Public Health Institutional Review Board approved the study procedures (IRB #00004707). As previously mentioned, approved documents (interview protocols, email template, and the oral consent form) are in the Appendix.

CHAPTER 4

RESULTS

This chapter presents results from the three study aims. The chapter begins with results from the legislative mapping research. This is followed by the results from the two state case study, where a general background of both state Offices of Minority Health, including demographics, mission, duties and roles, and staffing, are presented. The chapter then concludes with the results related to the Offices' development and implementation.

AIM 1 RESULTS

Overview

Six hundred and seven bills were analyzed. Between 2002 and 2011, 909 bills were introduced in 45 states specifically targeting racial and ethnic health disparities. No bills were identified from Idaho, Montana, North Dakota, South Dakota, and Wyoming. Of the 909 bills, n=607 were analyzed; of these, n=607 analyzed bills, n=330 bills were passed into law (54.4%). Of these, seven bills were ultimately vetoed by the state's governor. These bills were vetoed in California, Colorado, New York, Illinois, Indiana, and New Hampshire. The vetoed bills covered various topics, including Alzheimer's awareness, cultural competency, Native American health, and OMH representation.

As discussed in Chapter Three and shown in Table 1, introduced bills were classified into 11 different health disparities topic areas. On average, states addressed about 6 different topic areas (range 1-11 topics). Some general characteristics of introduced bills are shown in Table 2 below. Across all states, the range of unique lead sponsors of the bills ranged from 1 to 31, with an average of approximately 8 different lead sponsors per state. For example, in some states, the same legislator was the lead sponsor for multiple bills, whereas in other states, legislators tended to sponsor only one or two bills. On average, each unique lead sponsor proposed 1.7 bills, with a range of 1 to 4 bills. Introduced bills, on average, went through 1.5 versions within one session, ranging from 1 version to 10 versions, shared between both houses of the legislature.

Table 2. General Characteristics of Introduced Bills (N=909)

# of bills introduced	909
# of bills analyzed	607
# of bills passed	330
Avg. # of unique bill sponsors per state (min 1, max 31)	7.9
Avg. # of bills per sponsor (min 1, max 4)	1.7
Avg. # of bill versions (min 1, max 10)	1.5

On average, approximately 60 bills were introduced each year from 2002-2011. Out of the 607 bills analyzed, 330 were passed into law for an overall passage rate of 54.4% from 2002-2011. The highest number of bills was introduced in 2007, and the fewest number was introduced in 2002. About 55% of bills passed into law on average each year

from 2002-2011, with the highest proportion of bills passed in 2008 (64.8%), and the lowest in 2011 (45.9%) (Table 3). Overall, there was no clear pattern in the passage rate by year.

Table 3. Yearly Trends of Bills Analyzed, 2002-2011

Year	Total Introduced	Total Passed	Percent Passed (%)
2002	34	20	58.8
2003	58	33	56.9
2004	63	37	58.7
2005	71	33	46.5
2006	71	41	57.7
2007	77	39	50.6
2008	54	35	64.8
2009	67	36	53.7
2010	51	28	54.9
2011	61	28	45.9
Total	607	330	54.4
Average (per year)	60.7	33	54.9

Characteristics of States Included in Analysis, 2002-2011

As previously noted, 45 states had at least one bill that was included in this analysis.

These states varied by geography, demographics, and political variables (Table 4).

According to data from the U.S. Census, during this time frame, overall, the non-White, non-Hispanic population among these 45 states averaged approximately 19%. From 2002-2011, the Hispanic population for these states averaged 10.2%, compared to 15.1% for the U.S. In addition, Republicans controlled the legislature in most states for most of the study period, while Democrats controlled the governor's office.

Table 4. Characteristics of States Included in Analysis

	States in Analysis (n=45)	U.S. Average
Average non-White, non-Hispanic Population, 2002-2011 (%)	19.7	18.5
Average Hispanic Population, 2002-2011 (%)	10.2	15.1
Average Median Income, 2002-2011 (\$)	47,985	47,423
Avg. # of Legislature Dem-controlled years, 2002-2011	4.6	N/A
Avg. # of Governor Dem-controlled years, 2002-2011	5.2	N/A
Avg. # of Categories used (min 1, max 11)	6.1	N/A

Categorical/Topical Areas

As previously mentioned, the bills were coded on eleven categories/topical areas (Table 7). During the study period the number and percentage of bills introduced by category varied by year (Tables 8 and 9, respectively). The next section includes a brief description of those categories/topical areas and related results. Because each bill could be classified in more than one sub-category, the percentages presented will not sum to 100 percent. Examples of the bills from each category are located in Appendix F.

Infrastructure

Infrastructure-related bills, which addressed organizations tasked with eliminating racial and ethnic health disparities such as OMH and related task forces/committees, were the

most common bills identified (43.2%). This category included three subcategories, which were OMH, task forces/committees, and representation. Those bills coded as representation included bills directing the OMH to be represented on a task force/committee, such as those focused on health literacy, child health, or some other non-health disparities-specific area.

In general 44.9% of these infrastructure bills targeted OMH (24.0% of all analyzed bills overall), 41.0% addressed health disparities task forces and/or committees (22.0% of all bills overall), and 14.1% directed representation of the state OMH on a task force or committee, such as a task force on child health or health literacy (7.6% of all bills overall).

Forty-three states introduced bills related to infrastructure in general. Thirty-two states addressed OMHs, 35 states addressed task forces/committees, and 10 states used legislation to require OMH representation on a task force or committee.

Appropriations

Thirty-two states had at least one bill appropriating funds for health disparities activities. Forty-one percent of all bills coded were classified as appropriations bills (n= 250). Appropriation bills were targeted to health departments, OMHs, task forces, programmatic efforts, community-based organizations, and academic centers.

Appropriation bills also created grant programs as a mechanism to allocate health disparities funds from the state to local organizations. Appropriations included bills allocating a specific amount of funding to health disparities activities within the state and bills designating mechanisms to direct funds to health disparities efforts. A common example of appropriation bills targeting racial and ethnic health disparities was to mandate a specific percentage of cigarette or tobacco taxes towards programs to eliminate racial and ethnic health disparities or improve minority health.

Disease-Specific

Twenty-seven states targeted a particular disease through health disparities legislation. These bills represent 25.0% of the entire sample (n=152). Bills were coded as disease-specific if the legislation targeted only one disease or condition rather than two or more diseases or conditions. Bills included in this category focused on infectious and chronic diseases, injury prevention, mental health, and behavioral health. The most common disease targeted through introduced legislation was HIV/AIDS. Lupus, cancer (general), mental health, and infant mortality rounded out the top 5 diseases targeted in legislation (Table 5).

As shown in Table 6, the number of bills introduced targeting a specific disease varied by year. Only one disease, HIV/AIDS, was the target of at least one piece of legislation in each year throughout the entire study period (average 3.8 bills introduced per year). Some

diseases were a focus at the beginning of the study period but became less popular towards the end, such as prostate cancer (Table 6). Other diseases were not a specific focus of legislation until the latter part of the study period. For example, lupus was not a specific focus in state legislation targeting racial and ethnic health disparities until 2007, and continued to be a focus until the end of the study period in 2011. Finally, some diseases were a focus of state legislation cyclically, such as substance abuse.

Table 5. Top 5 Diseases Targeted by State Racial and Ethnic Health Disparities Legislation, 2002-2011⁵

Disease/Condition	Percentage (of all disease-specific bills)
HIV/AIDS	25.00
Lupus	13.82
Cancer	9.87
Mental Health	8.55
Infant Mortality	5.92

⁵ Cardiovascular disease, obesity, and diabetes do not appear on this list due to the coding method used. This analysis focused on bills targeting single diseases; cardiovascular disease, obesity, and diabetes tended to be discussed together in the analyzed state bills rather than singularly.

Table 6. Count of Diseases Targeted by Proposed State Racial and Ethnic Health Disparities Legislation by Year, 2002-2011

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	Total	Average/ Year
Alzheimer's	0	0	1	1	0	1	0	0	0	0	3	0.3
Asthma	0	0	0	0	0	1	1	0	1	1	4	0.4
Behavioral Health	0	0	1	1	0	0	0	0	0	0	2	0.2
Birth Outcomes	0	0	0	0	0	0	0	0	0	1	1	0.1
Bone Marrow	0	0	1	0	0	0	0	0	0	0	1	0.1
Cancer (general)	0	2	1	2	1	2	4	1	1	1	15	1.5
Cervical and Breast Cancer	0	0	0	0	1	0	0	0	0	1	2	0.2
Cervical Cancer	0	0	0	2	1	1	0	0	0	0	4	0.4
Colorectal Cancer	0	0	0	1	0	0	0	0	2	0	3	0.3
End-of-Life	0	1	0	0	0	0	0	0	0	0	1	0.1
Hepatitis B	0	0	0	0	1	0	0	0	0	0	1	0.1
HIV/AIDS	3	5	3	6	4	5	3	5	2	2	38	3.8
Human Trafficking	0	0	0	0	0	1	0	0	0	0	1	0.1
Infant Mortality	1	1	0	1	0	2	0	1	0	3	9	0.9
Kidney Disease	0	0	0	2	1	1	1	0	0	0	5	0.5
Lead Poisoning	0	0	0	0	0	1	0	0	0	0	1	0.1
Lupus	0	0	0	0	0	1	3	6	4	7	21	2.1
Mental Health	2	0	0	0	2	2	1	2	2	2	13	1.3
Prostate Cancer	1	1	1	1	1	0	0	0	0	0	5	0.5
Reproductive Health	0	0	1	1	0	0	0	0	0	0	2	0.2
Sickle Cell	0	0	0	1	0	2	0	1	1	2	7	0.7
Stroke	0	1	1	1	0	0	1	0	0	0	4	0.4
Substance Abuse	0	1	0	1	0	0	0	1	1	0	4	0.4
SUID ⁶	0	0	0	0	0	0	0	0	0	1	1	0.1

⁶ SUID: Sudden Unexpected Infant Death

Teen Pregnancy	0	0	1	1	0	0	0	0	0	1	3	0.3
Tobacco	0	0	0	0	0	0	0	1	0	0	1	0.1
Total	7	12	11	22	12	20	14	18	14	22	152	15.2

Data Collection, Reporting, and Planning

Approximately 16.5% (n=100) of all bills were coded under data collection, reporting, and planning. These bills addressed data collection related to health disparities by various actors, such as the health department; the reporting of health disparities data, usually annually; or planning for programmatic efforts towards eliminating health disparities in the state. Fourteen states introduced bills in this category.

Cultural Competency

Twenty-one states used legislation to address cultural competency, which represented 14.0% (n=86) of all bills analyzed. Cultural competency in health is generally defined as an understanding of the impact of social and cultural practices on health beliefs and behaviors and designing health interventions and health care in a manner that is culturally and linguistically appropriate (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003). In general, cultural competency bills targeted physicians and other providers within the health care system rather than a broader public health population. Bills called for training and education in cultural and linguistic competency, mainly among physicians or those health care providers licensed by the state. Additionally, some bills focused on cultural competency education within universities training health care professionals, including

physicians and nurses. A few proposed bills created infrastructure related to cultural competency (e.g., task forces or committees), and some called for data collection and reporting related to the cultural background and language proficiency of licensed health care providers.

Workforce

Twenty-one states introduced bills specifically directed towards the public health and healthcare workforce, representing about 11.0% (n=68) of all bills analyzed. These bills included legislation targeting increased diversity within the public health workforce; creating requirements for physician training in cultural competency and other areas related to racial and ethnic health disparities; and incentives to increase workforce diversity such as loan repayment programs.

Recognition/Awareness

Bills coded under recognition/awareness included bills that recognized the existence of health disparities within the state or to increase awareness of health disparities among legislators and other actors (e.g., non-health organizations or citizens statewide). These bills represented 9.6% (n=46) of all bills analyzed and were introduced in 22 states. Typically, these bills did not include substantive policies or mandates for particular action. For instance, some of the recognition/awareness bills recognized April as

“Minority Health Month” or highlighted data related to racial and ethnic health disparities to improve legislators’ knowledge and awareness of health disparities in the state.

Race- and Ethnic-Specific

Race- and Ethnic-specific bills were bills focusing on one specific racial or ethnic group, such as African American, Hispanic, Asian/Pacific Islander, and American Indians/Alaskan Natives. Bills were not coded as race-specific if multiple racial and ethnic groups were specified in the proposed legislation. Twenty-four states targeted a particular racial and ethnic group in proposed health disparities legislation, and race-specific bills constituted about 9.0% (n=54) of all analyzed bills. American Indians/Alaskan Natives were the highest targeted racial and ethnic group in race-specific bills (43.6%), followed by African Americans (34.5%), Hispanics (14.5%), Asian/Pacific Islander (5.4%), and Native Hawaiian (1.8%). Some of these bills targeted a particular disease that impacts certain racial and ethnic groups at a higher rate than other population groups, such as lupus or sickle cell disease.

Research Study

Research study bills targeted increasing the number of racial and ethnic groups in research studies or directed certain organizations to conduct research studies that would impact health disparities populations. Seven states introduced bills under this category

and these bills represented less than 5.0% (n=29) of all bills in this study. Some of the research topics that were highlighted included: the social determinants of health, health disparities among minority children and young adults, health disparities in minority groups with special needs (e.g., those with learning disabilities), health care disparities, cultural and linguistic issues in health care, and health disparities among different racial and ethnic groups in general.

Trends in Bills by Topic

Table 7 shows the number of topics addressed by year in the sample of analyzed bills. Bills addressing infrastructure accounted for the highest number of bills introduced (n=262), followed by appropriations (n=250), and data collection/reporting/planning (n=100). Within infrastructure, 146 bills targeted OMHs, 133 focused on task forces/committees, and 46 addressed representation.

As shown in Table 8, some topical areas grew in the proportion of total bills introduced over the study period. For example, in 2002, data collection, reporting, and planning bills represented approximately 9.0% of all bills introduced that year; however, 2011 this percentage grew to approximately 26.0%. Similarly, bills addressing task forces and committees grew from 8.8% of all bills introduced in 2002 to 23.0% in 2011. Other topic areas decreased in frequency, such as race-specific bills (11.8% in 2002 to 3.3% in 2011). The number of topics covered tended to not decrease or increase linearly, but cyclically,

with ebbs and flows during the study period. For example, between 2002 and 2006, cultural competency bills increased from 11.8% to 23.9%, and then decreased to 11.7% of all bills introduced in 2007.

Table 9 shows the proportion of introduced bills that passed or failed by topic. Bills falling under recognition/awareness had the highest passage rate (72.4%), which was defined as bills to increase knowledge about racial and ethnic health disparities or to recognize different racial and ethnic health disparities within the state. Data collection/reporting/planning bills were the least successful with a passage rate of only 36%.

Table 7. Count of Yearly Trends of Bills Analyzed by Topic, 2002-2011

Category	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	Total
Appropriations	19	25	18	28	27	38	21	34	18	22	250
Data Collection/ Reporting/ Planning	3	7	12	9	11	14	8	13	7	16	100
Research Study	1	4	5	4	2	6	2	4	0	1	29
Cultural Competency	4	6	9	10	17	9	6	10	6	9	86
Race Specific	4	6	6	9	3	6	8	8	2	2	54
Infrastructure	10	29	31	26	32	40	21	26	24	23	262
OMH	6	11	17	14	23	25	10	15	12	13	146
Task Force/Committee	3	19	15	13	10	17	15	14	13	14	133

Representation	1	8	3	4	7	7	5	4	2	5	46
Workforce	4	4	6	7	10	9	5	12	4	7	68
Recognition/ Awareness	4	7	5	9	7	2	9	3	7	5	58

Table 8. Topic Areas as a Percentage of Total Bills Introduced by Year, 2002-2011

Category	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	Overall Average
Appropriations	55.9	43.1	28.6%	39.4	38.0	49.4	38.9	50.7	35.3	36.1	41.2
Data Collection/ Reporting/ Planning	8.8	12.1	19.0	12.7	15.5	18.2	14.8	19.4	13.7	26.2	16.5
Research Study	2.9	6.9	7.9	5.6	2.8	7.8	3.7	6.0	0.0	1.6	4.8
Cultural Competency	11.8	10.3	14.3	14.1	23.9	11.7	11.1	14.9	11.8	14.8	14.2
Disease Specific	20.6	20.7	17.5	31.0	16.9	26.0	25.9	26.9	27.5	36.1	25.0
Race Specific	11.8	10.3	9.5	12.7	4.2	7.8	14.8	11.9	3.9	3.3	8.9
Infrastructure	29.4	50.0	49.2	36.6	45.1	51.9	38.9	38.8	47.1	37.7	43.2
OMH	17.6	19.0	27.0	19.7	32.4	32.5	18.5	22.4	23.5	21.3	24.0
Task Force/ Committee	8.8	32.8	23.8	18.3	14.1	22.1	27.8	20.9	25.5	23.0	21.9
Representation	2.9	13.8	4.8	5.6	9.9	9.1	9.3	6.0	3.9	8.2	7.6
Workforce	11.8	6.9	9.5	9.9	14.1	11.7	9.3	17.9	7.8	11.5	11.2
Recognition/ Awareness	11.8	12.1	7.9	12.7	9.9	2.6	16.7	4.5	13.7	8.2	9.6

Table 9. Passage Percentages by Topic, 2002-2011

	Pass	Fail
Recognition/Awareness	72.4%	27.6%
Appropriations	67.6%	32.4%
Representation	56.5%	43.5%
Research Study	55.2%	44.8%
Infrastructure	54.6%	45.4%
Task Force/Committee	54.1%	45.9%
Disease-Specific	52.0%	48.0%
OMH	51.4%	48.6%
Race Specific	49.1%	50.9%
Workforce	41.2%	58.8%
Cultural Competency	40.7%	59.3%
Data Collection/Planning/Reporting	36.0%	64.0%

Geographical Variation

There was geographical variation in the number of bills introduced from 2002-2011. As shown in Figure 2, the average number of bills introduced per state was approximately 13, with four states introducing 30 or more bills (New York, California, Florida, and Arkansas) and 14 states introducing 5 or fewer bills (Kansas, Vermont, Hawaii, West Virginia, Alaska, Kentucky, Maine, Arizona, Louisiana, Alabama, Oklahoma, South Carolina, Virginia, and Wisconsin). States also varied on the categories/topics addressed in their bills. On average, states introduced bills covering about six different health disparities categories (Figure 3). Eight states addressed 3 or fewer topics (Alaska, Kansas, Michigan, Nevada, South Carolina, West Virginia, Wisconsin, and Vermont) and

six states targeted 10 or 11 topics (Arkansas, Florida, Illinois, Maryland, New Jersey, and New Mexico). States that introduced more than the average number of bills (15 states) tended to also address more health disparities topics in those bills compared to states that introduced fewer than 13 bills from 2002-2011 (8.3 topics and 5.03 topics, respectively).

Geographical variation was determined using the Census classifications for geographic regions (Northeast, South, Midwest, and West) and geographic subregions (New England, Middle Atlantic, South Atlantic, East South Central, West South Central, East North Central, West North Central, Mountain, and Pacific), which are somewhat similar to the Department of Health and Human Services regions. Overall, the most bills were introduced in the South and the fewest in the West. As shown in Table 10, states in the Midwest Census region were most likely to use bills for appropriations, research studies, and disease-specific topics. In the South, bills tended to be categorized as OMH, task force/committee, recognition/awareness and research study. In the Northeast Census region, bills were most likely to be categorized as disease-specific, workforce, and OMH. States in the West Census region tended to introduce bills categorized as race-specific, cultural competency, and workforce. There was also geographic variation in the number of categories/topics each state used. On average, states addressed approximately 6 topics (range 1-11). Only two states addressed all 11 topics (Florida and Maryland).

As previously mentioned, there were different passage rates for bills addressing various topics. Similarly, there are geographical variations in bill passage rates (Table 11). Bills introduced in the Midwest Census region had the highest passage rate of 64.7%, followed by the West Census region (61.5%), the South Census region (53.0%), and, finally, the Northeast Census region (42.6%). Variation was also observed among the nine Census subregions . Bills in the West South Central Census subregion had the highest passage rate of all of the Census subregions at 82.0%. Bills in the Middle Atlantic region had the lowest passage rate of all of the Census subregions at 37.5%.

Figure 2: Number of Racial and Ethnic Health Disparities Bills Introduced by State, 2002-2011

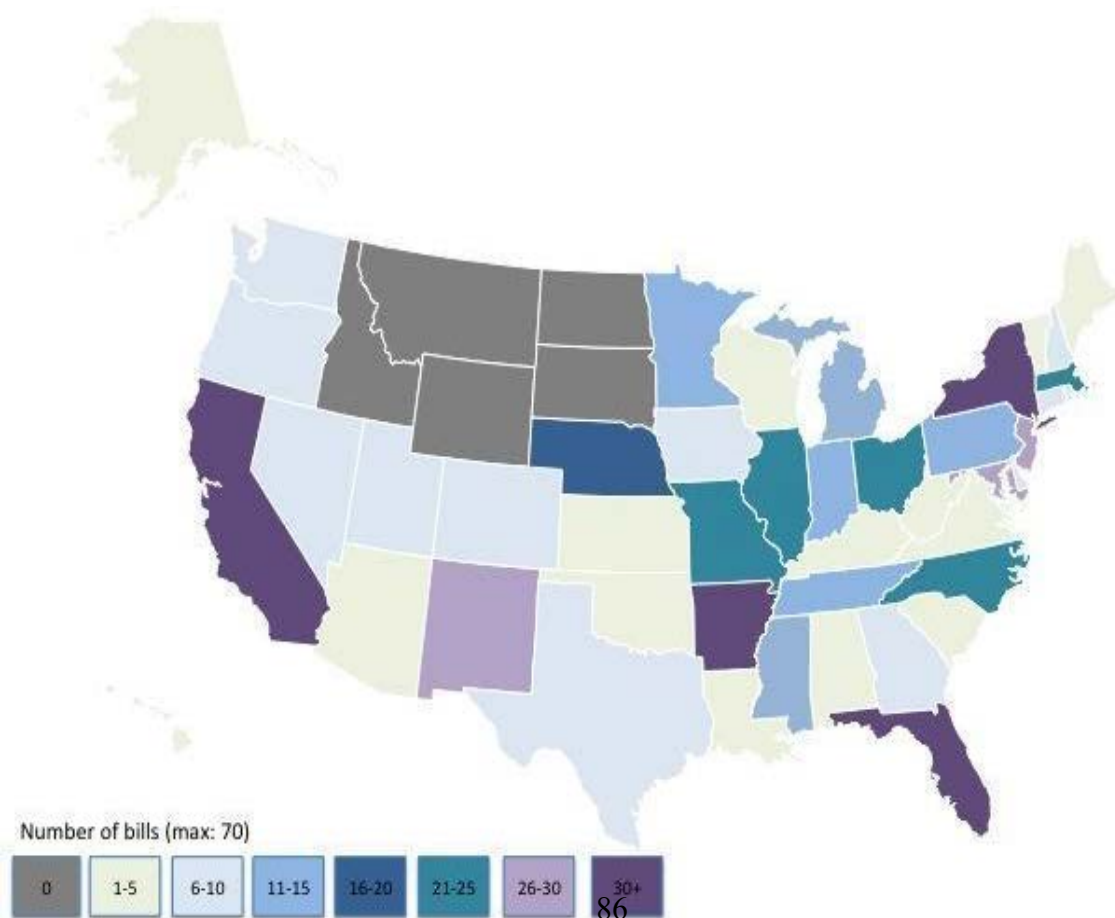


Figure 3. Number of Racial and Ethnic Health Disparities Bill Categories Introduced by State, 2002-2011

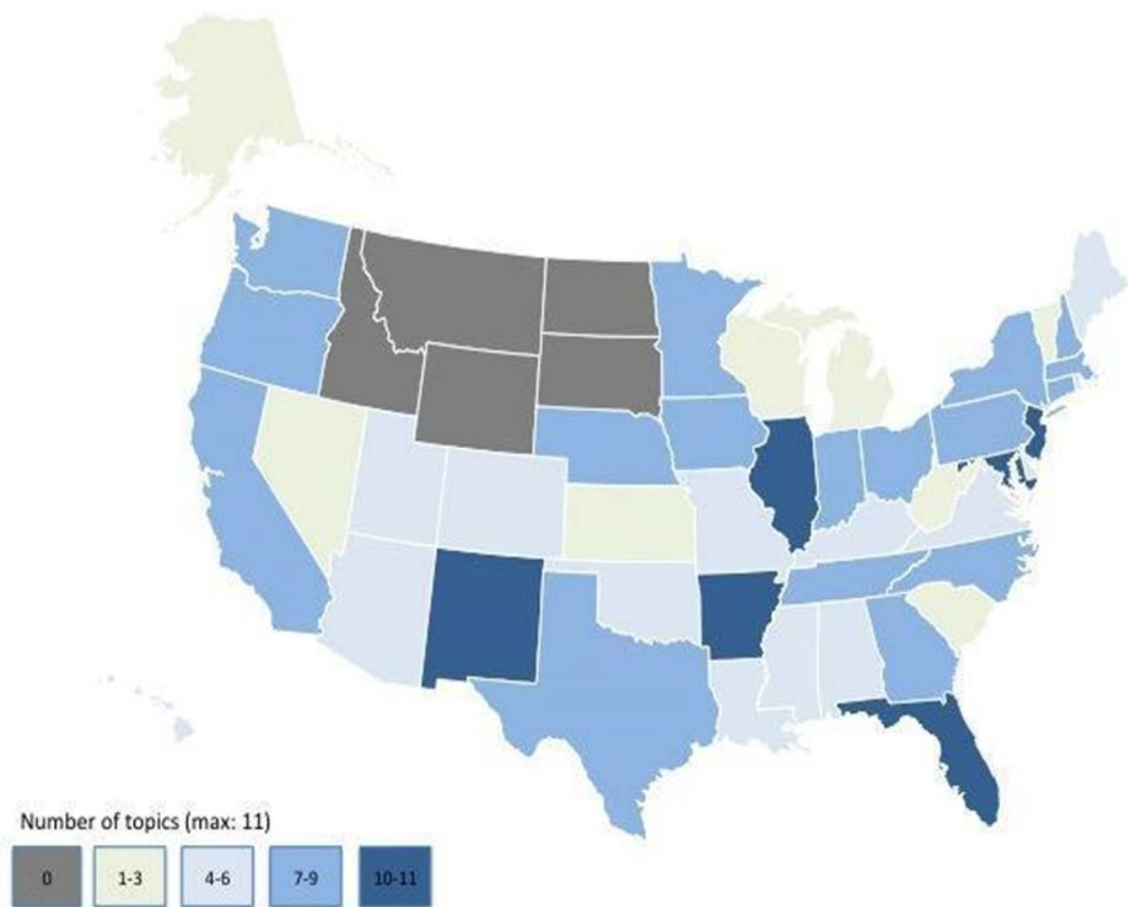


Table 10. Geographic Variation in State Legislation Introduced to Eliminate Racial and Ethnic Health Disparities by Census Regions, 2002-2011

	% of total bills introduced (n=607)	Appropriations (n=250)	Data Collection/Reporting/Planning (n=100)	Research Study (n=29)	Disease Specific (n=152)	Race Specific (n=34)	OMH (n=146)	Task Force/Committee (n=133)	Representation (n=46)	Workforce (n=58)	Cultural Competency (n=86)	Recognition/Awareness (n=58)
MW	22.4%	33.2%	17.0%	31.0%	21.7%	20.4%	17.1%	15.8%	15.2%	14.7%	9.3%	17.2%
NE	26.7%	24.4%	26.0%	13.8%	43.4%	13.0%	36.3%	23.3%	26.1%	36.8%	36.0%	19.0%
SO	32.5%	30.4%	35.0%	37.9%	23.7%	20.4%	30.8%	40.6%	41.3%	26.5%	25.6%	37.9%
WE	18.5%	12.0%	22.0%	17.2%	11.2%	46.3%	15.8%	20.3%	17.4%	22.1%	29.1%	25.9%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Table 11. Geographic Variation in State Legislation Passed to Eliminate Racial and Ethnic Health Disparities by Census Regions and Subregions, 2002-2011

Region	Number Passed	Total Introduced	Percent Passed
Northeast	69	162	42.6%
New England	27	50	54.0%
Middle Atlantic	42	112	37.5%
South	106	200	53.0%
South Atlantic	52	120	43.3%
East South Central	13	30	43.3%
West South Central	41	50	82.0%
Midwest	88	136	64.7%
East North Central	50	76	65.8%
West North Central	38	60	63.3%
West	67	109	61.5%
Mountain	31	52	59.6%
Pacific	36	57	63.2%
Grand Total	330	607	54.4%

AIMS 2 AND 3 RESULTS

The objective of the case study portion of this research was to document and understand the development and implementation of two state OMHs (MD and FL). The following demographic and background descriptions were collected from each state OMHs website and other documentation, such as publically available reports, data collection, or documents shared by interviewees themselves. The descriptions are followed by the results from the interview data collected as part of the case study.

Maryland Demographics and Office Background

Demographics

U.S. Census 2013 estimates show that Maryland is home to over 5.9 million residents. White, non-Hispanics comprise approximately 61% of the total population. Of the remaining 40% non-White non-Hispanic population, 30.0% are Black or African American; 0.5% are American Indian and Alaska Native; 6.0% are Asian; and 0.1% are Native Hawaiian and Other Pacific Islander.

Across all races, approximately 9.0% of the population is Hispanic or Latino. The overall population grew at about 3.0% between April 1, 2010 and July 1, 2013. Among those aged 25 and over, almost 90.0% are high school graduates, and 36.3% have at least a Bachelor's degree. The median household income between 2008 and 2012 was about

\$73,000. Almost 10.0% of the Maryland population lived below the poverty line between 2008 and 2012.

Office Background

The Maryland Office of Minority Health and Health Disparities (MD MHHD) was established through House Bill 86 and Senate Bill 177 in 2004. Delegate Shirley Nathan-Pulliam sponsored H.B. 86, and the lead sponsor for S.B. 177 was Senator Nathaniel Exum. The bill passed the House of Delegates with a vote of 135-1 (one Republican voted in opposition to the bill; reason unknown), and, shortly after, passed the Senate with a vote of 47-0.

The bill went through three readings and was passed with amendments from both the House of Delegates and Senate. The amendments included the addition of other delegates as co-sponsors, insertion of different language, such as adding the phrase “and Health Disparities” to the name of the office (to become the Office of Minority Health and Health Disparities), language indicating where funding should come from (“it is the intent of the general assembly that the office be funded from federal and special funding sources”), and other technical changes. These amendments are important to note, because these changes may have been influential in the bill’s passage. For example, the first reading of the bill indicated that MHHD would have 21 mandated roles and responsibilities, but the final version has 22 (MD Code Annotated §20-1001 through §20-1007).

There were also structural changes between the different versions of the bill. For example, the original bill version mandated the head of the Office of Minority Affairs as the director of MHHD. Roles and duties of the office were also addressed through amendments. The first version of the bill indicated that the office would be responsible for examining “the financing and access to health services for Maryland’s minority populations.” That language was eliminated and not replaced in the final bill. The bill also intended to create a 15-member “Minority Health Commission,” which would be responsible for advising the director of MHHD, review and make recommendations to the office, and provide other assistance as needed. This provision of the bill was changed to a mandate directing MHHD to assess “the establishment of a minority health advisory commission to be composed of representatives from the legislative and executive branches that would assist the Office of Minority Health and Health Disparities.” Additional roles of MHHD were added as amendments, such as mandating planning requirements. The sponsors of the original bill also mandated that the office would have staff “as provided in the state budget” and provide staff to the Minority Health Commission as needed.

The bill establishing the MD MHHD became effective October 1, 2004. The bill was a standalone bill; that is, this bill was focused exclusively on the office and not attached to any other bill.

Mission/Vision

The mission of the MD MHHD as noted on their website (MD MHHD, 2014) is:

In fulfillment of the Department's mission to promote the health of all Maryland citizens, the Office of Minority Health and Health Disparities shall focus the Department's resources on eliminating health disparities, partner with statewide organizations in developing policies and implementing programs, and monitor and report the progress to elected officials and the public. The target ethnic/racial groups shall include Native Americans, African Americans, Hispanic/Latino Americans and Asian Americans.

Office Structure

The MD MHHD is located in the MD Department of Health and Mental Hygiene. The Director of the MD MHHD reports directly to the MD Secretary of Health, which is mandated in the statute establishing the office.

Duties/Roles

The statute outlines 22 duties MHHD is tasked with implementing and managing, which are distributed among the following categories: Education and Policy Advocacy; Managing Grant Programs (Minority Outreach and Technical Assistance); Annual Maryland Health Disparities Conference; Minority Health Disparities Reduction Demonstration Project; Cultural Competency and Health Workforce Diversity; Department of Health and Mental Hygiene Systems Change; Health Disparities Data; and Women's Health and Men's Health. MHHD maintains a website that includes documents and announcements related to these initiatives. The following are descriptions of these initiatives.

Education and Policy Advocacy: MD MHHD plays an integral part in public education regarding racial and ethnic health disparities in the state. One aspect of the education efforts is data reporting, including the *Maryland Plan to Eliminate Minority Health Disparities: Plan of Action 2010-2014* and the second edition of the *Maryland Chartbook of Minority Health and Minority Health Disparities Data*. In addition to publishing the *Maryland Chartbook*, MHHD collects racial and ethnic health disparities data by population group. The MD MHHD maintains a database of health disparities data, including race- and ethnic-specific data (i.e., health data on African Americans, Hispanic, Native American, and Asian populations in Maryland). In terms of policy advocacy, the office participates in the policy process, and its activities include providing testimonies and education related to proposed bills, recommendations, and reviews of existing laws and regulations.

Another education and awareness activity managed by the MD MHHD is the Annual Maryland Health Disparities Conference. The purpose of this conference is to connect those working on health disparities issues and to share practices, research, and strategies to eliminate racial and ethnic health disparities in Maryland. On average, the conference attracts a few hundred participants each year. Materials from past conferences, such as PowerPoint presentations and handouts, are publically available on the MD MHHD website. Typically, the conference is hosted as a statewide conference; however, in 2013, MD MHHD held, for the first time, a regional conference focused on health disparities and minority health in the Eastern Shore.

Managing Grant Programs (Minority Outreach and Technical Assistance): One of the main grant programs sponsored by the MD MHHD is the Minority Outreach and Technical Assistance (MOTA) Program: The MOTA program began in 2000 as a part of the Cigarette Restitution Fund Program (CRFP) and became the responsibility of MHHD in 2004. This program was originally intended to support community-based involvement of minorities in the education and planning of cancer and tobacco health programs. MOTA's scope was expanded in 2010 to include all racial and ethnic health disparities. This program provides grants statewide to organizations to work on health disparities issues in partnership with local health departments and other local organizations.

Another grant program managed by the MD MHHD is the Minority Health Disparities Reduction Demonstration Project. This grant program, initiated in 2008, provides cooperative grant agreements to local health departments to focus on minority health disparities. Grant funds are used to improve and support infrastructure and capacity building efforts using community-based approaches. These approaches include community health workers, coalition building, and outreach. There are currently five demonstration projects across the state; two are focused on cardiovascular disease and three are focused on improving minority infant mortality.

Minority Health Activities:

Cultural Competency and Health Workforce Diversity: The purpose of this initiative is to increase diversity in the Maryland health workforce. This initiative is based on partnerships with health professional schools in Maryland; details about which schools

this initiative focuses on were not available on the website due to a broken link. MD MHHD also works to increase the Maryland health workforce diversity through encouraging and support the adoption of cultural competency best practices, workforce data collection, and seeking funds to support organizations to recruit minority students into the health workforce. MHHD also hosts a Cultural Competency Workgroup. As a part of this initiative, MHHD provides written information and guidelines about cultural competency, which includes a training guide, resource kit, and an outline of cultural competency standards.

Department of Health and Mental Hygiene Systems Change: This initiative is an internal effort to apply a systems change approach within DHMH. The office collaborates with DHMH program offices to bring a greater focus on health disparities throughout the department, including the HIV/AIDS Administration, Emergency Preparedness and Response Administration, Environmental Public Health Tracking Program, and Medicaid.

Women's Health and Men's Health: The MD MHHD participates in activities to increase awareness of both women's and men's health issues. The office collaborates with other Department of Health programs to promote gender-based health. For example, for women's health, the Office collaborates with other programs and organizations such as the Maryland Commission for Women and the Women's Health Promotion Council, to collect data and plan outreach and educational events. The Office also provides resources related to men's health issues and related disparities.

Staffing

The MHHD works with a staff of about 12, including the director of the office. At the time of this study, the office has had the same director since its development in 2004. The statute mandates the duties of the director, such as promoting health and the prevention of disease among minority populations, distributing grants, and funding innovative and culturally sensitive projects to reduce the severity and incidence of diseases impacting minority groups.

Funding

The MD MHHD is funded through state funds, including funding from the Cigarette Restitution Fund program, and federal grants. Some of the state funding is through the MOTA program, which began with about one million dollars and was cut in half over time since 2004.

Logic Model

The MHHD operates based on a health disparities logic model, and expects its grantees to operate on the same model (Appendix G). There are five main components of this logic model: awareness; community/culturally competent outreach; leadership; coalitions/community task forces; and data and research. Each of these components has

related expectations that are monitored through grantee reporting. For example, under awareness, health disparities initiatives are expected to “increase awareness of minority adult cardiovascular disease or infant mortality among health organizations and non-health organizations with health impacts.” Grantees are also expected to “increase stakeholder knowledge about community-based interventions” and to “increase partnerships between health and social environment organizations.”

Florida Demographics and Office Background

Demographics

U.S. Census 2013 estimates show that Florida has about 19.5 million residents. White, non-Hispanics comprise approximately 78.0%. Of the remaining 22% non-White, non-Hispanic residents, 16.6% are Black or African American; 0.5% are American Indian and Alaska Native; 2.7% are Asian; and 0.1% are Native Hawaiian and Other Pacific Islander, 0.1%.

Across all races, 23.2% of the population is classified Hispanic or Latino population. The overall population grew at 4% between April 1, 2010 and July 1, 2013. Among all individuals aged 25 and older, 86.0% are high school graduates and 26.2% have at least a Bachelor’s degree. The median household income from 2008-2011 was about \$47,309. About 16.0% of the Florida population lived below the poverty line from 2008-2012.

Office Background

Florida has a history of addressing racial and ethnic health disparities in the state Department of Health. In 1993, the Minority Health Commission was authorized through the Florida Minority Health Improvement Act. After the Commission was sunset in 1995, the Department of Health established the Office of Equal Opportunity and Minority Health in 1998.

In 2004, the Office of Minority Health (OMH) became its own entity within the Florida Department of Health. The Office was established in 2004 through a vote by the state legislature. Based on the statute, the language establishing the Office was limited to one line (FL Statute Section 20.43 (9)). The language creating the Office was added in the third version of a larger bill (2004 FL S.B. 2448) as an amendment rather than as a standalone bill. The entire bill passed the FL Senate with a vote of 40-0, and the FL House of Delegates with a vote of 118-0.

Mission/Vision

According to the FL OMH website (FL Office of Minority Health, n.d.), there is no OMH-specific mission or vision outlined. The Department of Health mission and values are listed on the OMH “About Us” webpage. The mission is “To protect, promote, and improve the health of all people in Florida through integrated state, county, and

community efforts.” The values include innovation, collaboration, accountability, responsiveness, and excellence.

Background information from a document provided by the FL OMH does indicate the purpose of the OMH’s creation (FL Office of Minority Health, personal communication, May 21, 2014). The purpose of the OMH is to:

Serve as the coordinating office within the Department for consultative services and training in the area of cultural and linguistic competency, coordination, partnership building, program development and implementation, and other related comprehensive efforts to address the health needs of Florida’s minority and underrepresented populations statewide.

According to the OMH website, the Office is also “responsible for helping to improve health and healthcare outcomes for racial and ethnic minority communities by developing or advancing policies, programs, and practices that address health, social, economic, environmental, and other factors which impact health.”

Office Structure

The FL OMH is located in the FL Department of Health in the Office of the Secretary/Surgeon General. The director of the FL OMH reports to the Deputy Secretary for Health.

Duties/Roles

The duties of the FL OMH were not outlined in the legislation creating the Office. The website states that the FL OMH is responsible for the management of a few health disparities programs, including grant programs, minority health activities, and data collection, which are presented below.

Managing Grant Programs: The *Closing the Gap* (CTG) grant program is managed by the FL OMH, and is the Office's flagship program. CTG is a competitive grant program mandated by Florida state statute 381.7351, which was signed into law June 8, 2000. The purpose of CTG is to improve health outcomes among racial and ethnic populations and promote disease prevention through stimulating the development of community and neighborhood organizations.

CTG projects, according to the FL OMH website, are designed to stimulate "broad-based participation and the support of both public and private entities" through partnerships between local governments, community groups, and private sector healthcare organizations; targeted health screenings, education, and awareness programs; and helping communities understand the nature of health disparities.

There are seven priority areas for CTG:

- Cancer
- Cardiovascular disease
- Adult and child immunizations
- HIV/AIDS
- Maternal and Infant Mortality
- Oral healthcare

Staff from the FL OMH did provide some background information about the CTG grant program, such as amount of grants awarded over the last two fiscal years and the number of minorities reached. During Fiscal year 2012-2013, nine full year grants and 21 short-term mini grants were awarded to community-based organizations across the state for minority health activities. The total award amount was \$2,564,883. During Fiscal year 2013-14, 15 full year grants were awarded across the state to community-based organizations, totaling \$2,731,288. For this time period (2013-14), it is estimated that over 124,000 minorities will be reached through CTG grantee initiatives.

One published evaluation of the CTG by Rahman, Rahman, Vilme, & Hayes focuses on the impact of a community diabetes prevention program funded by CTG (2013). The authors concluded that the program was successful in recruiting minority populations, women, and hard-to-reach populations (Rahman et al., 2013). Study results also emphasized the importance of keeping evaluation in mind during program design; this emphasis was the result of the difficulty of determining changes in health outcomes based on the CTG program. An internal evaluation of the program was conducted in 2008 and is referenced in the Rahman et al. study, but the report was unable to be located on the FL OMH or Department of Health website. Additionally, a request to locate the evaluation report to the Department of Health was forwarded to the FL OMH; however, that request was not responded to nor fulfilled.

Minority Health Activities: The FL OMH sponsors minority health-related activities. The Office sponsored a health disparities conference in the early years of its

implementation; however, the education and awareness currently is accomplished through external partners. One way the Office seeks to administer education and improve awareness in local communities is through Minority Health Liaisons (MHLs). MHLs include a representative from each of Florida's 67 counties that serve as the link between the local health department and the state OMH. While the FL OMH does not identify an overall mission or vision for the Office, the Office does have a vision for the MHLs, which is to "develop a network of collaborative partnerships." The role of the OMH in achieving this vision is to:

- Coordinate with county health departments, central office divisions/bureaus, and statewide stakeholder, and;
- Providing technical assistance to the MHLs on issues related to minority health, health disparities, and other health issues within the state.

The OMH-MHL partnership has several key components as outlined on the website, including:

- Share information on minority health and health disparities
- Coordinate events designed to improve minority health, such as Black History Month, Asian American/Pacific Islander Heritage Month, Hispanic-Latino Heritage Month, American Indian and Native Alaska Heritage Month, Take a Loved One to the Doctor Day, National Minority Health Month, and other nationally recognized events;
- Develop statewide initiatives;
- Promote state and local activities and events to raise awareness of programs and services available to minorities and the underserved populations;
- Maintain an OMH presence at the state and local levels; and
- Help meet the mission of the Department of Health by achieving its primary responsibilities in eliminating health disparities.

The FL OMH observes several national minority health initiatives. These national initiatives tend to focus on a specific racial or ethnic group for a month. FL OMH

observes American Indian Heritage Month, Asian American and Pacific Islander Heritage Month, Black History Month, and Hispanic/Latino Heritage Month. Each of these observances has a health-related theme and includes activities, such as webinars, and presentations. Additionally, the FL OMH observes Minority Health Month (April) and Take a Loved One to the Doctor Day (third Tuesday in September).

According to the FL OMH website, the Office also maintains a Speakers' Bureau. The goal of the Speakers' Bureau is to support local and community-based health disparities organizations, including CTG grantees, by connecting them with a network of health experts. Speakers come from a variety of areas of expertise, such as promoting and increasing awareness on CTG health priorities (i.e., cancer, HIV/AIDS, etc.), cultural competency, capacity building, and funding/grant writing.

Data Collection: The FL OMH collects and maintains health disparities data on its website. The website links to a community health assessment tool called Florida CHARTS. From this tool, visitors can create minority health profiles by year and by county. The FL OMH also prepared minority health profiles by racial and ethnic group. Profiles currently available on the FL OMH website is a 2011 Black/White Minority Health Profiles, a 2011 Hispanic/Non-Hispanic Minority Health Profile, and a 2011 American Indian Minority Health Profile. At the time of document collection for this study, there were neither further updated profiles nor published profiles for Asian Americans and Pacific Islanders.

Staffing

It is unclear how large the current FL OMH staff is; no information on staff full-time equivalent was found on the website. Based on the website, there is currently an office director and a manager for the CTG program. No other information related to staffing was found on the website.

Funding

Current funding for the FL OMH includes a mixture of state and federal funds. However, the current amount of funding for the FL OMH was not available on the website.

Logic Model

Based on the FL OMH, it does not appear that FL has a logic model guiding the Office or the work of CTG grantees.

Interview Results

Interview data were analyzed thematically to examine and understand the experience of policy development and implementation of the two state OMHs. Each of the themes includes subthemes that are useful in understanding the experience of OMH implementation in both states and will be discussed below. Additionally, interviewees discussed various challenges they or their respective OMH face during the implementation process. These challenges are discussed throughout all of these themes.

Policy Development

Interviewees from both states did not discuss policy development of their respective OMHs in depth. Across both states interviewees believed that their respective OMH was created because the state legislature saw a need for the office; there was a perceived problem with health outcomes among racial and ethnic minorities, and the state legislatures decided there should be an entity focused on addressing this problem. While prevalent in both states, this sentiment was stronger in MD.

A few FL interviewees tended to discuss the perceived need of the OMH as more of a symbolic act resulting from political pressure than actually understanding the need for the Office or expecting the Office to make a difference. One of the individuals interviewed described this as follows:

I think there was a lot of pressure for them to roll this out. This is right on the heels of President Clinton's initiative and his Closing the Gap and...the federal grant, I think that it's kind of a peace offering to say, "Hey, we're trying to do something to deal with this issue," but I don't think that leaders of this state, our state governor-- we had Jeb Bush at the time-- really embraced it. I do think it was the peace offering. So it's like if it worked, it worked. If it failed, it failed. Who cares? –FL Partner

One FL interviewee discussed the development of the FL OMH as if the office was an afterthought rather than a high priority for the state legislature. As the interviewee notes, the legislation creating the FL OMH was not a standalone bill, but was a part of a larger bill, suggesting that the bill would not have passed on its own.

And I found out the history of that in that the legislature who was trying to pass legislation to create the Office of Women's Health, you know how they do at the end when somebody tags something on so a piece of legislation can get passed? That's how it got tagged on. –FL Partner

Further exploration of the bills did reveal that subsequent standalone bills related to the FL OMH were unable to pass. For example, because there was minimal language establishing the FL OMH, legislators in both the FL House and Senate introduced bills to provide guidance on the Office's purpose, duties, and structure. Versions of this bill were introduced at least two times since 2010 in both the House and the Senate, and have yet to pass.

A few interviewees discussed how health disparities were framed during the policy discussion. One interviewee from FL noted that during the policymaking process, bill sponsors and advocates deliberately did not focus on Black/African American health, but minority health in general. The interviewee felt that this strategy was used to ensure that the bill was seen as inclusive of all minority populations, not just Blacks/African Americans, and to garner support from other minority interest groups within the state legislature.

Some interviewees also discussed the movement away from the use of “health disparities” in policy discourse in favor of “health equity.” While this movement is not necessarily common in these two states, some interviewees did acknowledge that this trend exists in other states. A few FL interviewees suggested that the preference for “health equity” rather than “minority health” or “health disparities” is happening not only

because of increased understanding of the social determinants of health, but also because of the perceptions or connotations those terms carry.

And that's the reason that I really wanted to change the name, and that was my explanation of it, too. Just-- let's just call it what it is. People hear minority health-- they think race and ethnicity, and even though we're all the business of taking care of folks here in public health, and we've gotten it, those are the ones that experience the most disparate outcomes. Everybody has their own individual biases. –FL Partner

And at Ohio and some other places they are now "Health Equity" rather than "Minority". Some have tried to move to "Multicultural". They have tried to do it in various ways to move against that minority designation because so many people have negative and adverse reactions to that. –FL Partner

Some interviewees did discuss health disparities policy development in general. When this theme was discussed, interviewees from both states focused on the role of policy entrepreneurs, particularly the importance of political support and political will when developing health disparities bills. Such political support comes in the form of coalitions that bring together various interest groups to support a bill, as well as have strong legislative leaders, like a policy entrepreneur. Interviewees from both states believed that there were political leaders within their state legislature who were champions of minority health, and were committed to eliminating racial and ethnic health disparities.

Other support resulted from advocacy outside of the legislature, such as local leaders working directly with the community and community members who understand the policymaking process and have the ability to advocate for health disparities policies at the state level. A few interviewees from both states agreed on the importance of local

understanding of the policy process and advocacy to advance minority health issues. The following quote from one participant describes this perspective:

In terms of this process is not an easy one because how many delegates do we have, there's only one. But at the same time we need to be vigilant in terms of knowing what to do, how to do in terms of advocacy and being engaged and involved and that's the reason why the whole model about [local] capacity building is so important. –MD Partner

Interviewees from both states also discussed the role of data in supporting health disparities policy development. Data was used to describe the extent of the problem the policy was proposing to address, and if the policy was previously successful.

Yes, it's essential because who's going to accept an idea if you can't show them that it's sound. You can't show them that it's working in some other places, and you can-- you can't do any indication of the cost. –MD Administrator

Referring to the development of the state OMH, one MD interviewee observed that the state legislature saw the need for an office focused on minority health and health disparities, especially after data was shared comparing MD's health outcomes with other states:

Because they saw the need in Maryland. Maryland's a very diverse state. I mean, almost half the population is minority population in Maryland. So I think looking at that, they recognized, "Okay. We're really having some issues." Especially when we started comparing our rankings to other states. Infant mortality, for instance. Our infant mortality, of 50 states, we're 43. Last time I checked think we were like 43. That means there's only seven other states that are worse than us. That's pretty bad. – MD Administrator

The use of data in policy development was also discussed in FL. Policy development does not only include introducing new policies, but also includes updating, revising, or continuing an existing policy, in which data plays a role. Some interviewees discussed

the use of data to demonstrate the policy outcomes for the purpose of policy continuation. These interviewees believed that using data to support an existing health disparities policy enabled the legislature to understand the role the policy played and the impacts the policy had and continues to have in their state.

One interviewee in MD indicated that data played a role in expanding the office's duty. For examples, once the office was able to collect and present data to the state legislature about the impacts the office generated through its grant program, the targeted diseases in the MOTA program were expanded.

One interviewee, a state legislator, discussed the importance of understanding the structure of the policy process within the state. While not a common topic across participants, this interviewee discussed that in FL, each state representative was only allowed to introduce a limited number of bills each session. Additionally, if a bill was introduced in the House, there should also be a Senate sponsor on the bill. This structure impacted the probability of a bill's passage.

Interviewees in both states felt that health disparities policymaking within their respective states would continue. However, MD interviewees were more optimistic about the outlook of health disparities legislation in their state than the FL interviewees, who tended to discuss future health disparities legislation in a hopeful or aspirational tone rather than with confidence. The perspectives of interviewees from MD and FL capture this confidence and hope, respectively:

I think the population in Maryland is going to continue to evolve and it's going to continue to change. I don't think health disparities is, the work on health disparities in Maryland, is going anywhere. Therefore I don't think the legislation to address it is going to go anywhere. If anything, I see more legislation being put into place in order to address it. More funding going towards addressing health disparities. – MD Administrator

I just hope that we can get a-- well, I hope we can get some new legislation, some stronger legislation and better-focused legislation and a couple of these people in the legislature who will really be supportive of the Office of Minority Health. We really need support. –FL Administrator

A couple of interviewees in FL discussed factors related to health disparities policy development. As the following quotes show, these interviewees focused on the role of coalition building, interest groups, and broad legislative support.

I would get the leadership involved on the front-end, the legislative leadership. If you can get the President of the Senator or Speaker of the House to agree on a front-end, that it will be a priority for them, then you will be much more likely to be able to get it passed, but you have to be able to show them why it's so important. And being able to find a way to connect the negative impacts of these disparities to that person, their families or someone that's close to them is where I believe you'll start to see a difference. –FL Legislator

And so, again, led by the Black Caucus, not until recently have we had a Hispanic Caucus nor an Asian Caucus, so led by that caucus, they put together the language and it was actually it came to pass. So, I think that's a testament to, again, that members of the Black Caucus who really understand the need and really are keeping up hope from what is going on in their individual counties but also across the state. –FL Administrator

One MD interviewee discussed the role of creativity in health disparities policymaking when faced with political opposition. This perspective included being flexible in policy mandates and requirements and persistence, and was described as follows:

And one of the other bills that I put in was to kind of mandate the curriculum, the cultural competency training for physicians and nurses and different groups.

Well, they came out at me with both feet. They were really angry that they don't want me to-- the universities did not want me to mandate their curriculum. So, I had to change the bill to make it highly recommended. –MD Legislator

The interviewee also noted flexibility in indicating how the proposed policy would get funding. When discussing the policy development of the MD OMH, the interviewee stated that one factor in its successful passage was the securing of non-state funding provided by stakeholders:

The bill came because I was able to get those in kind contributions from the different-- from University of Maryland, from Maryland State University, from Hopkins, from different places that would give me in kind. They would provide a secretary. They would provide this and provide that...Yes, so that's how I was able to get the bill passed. –MD Legislator

Office Implementation

Implementation of the state OMHs was widely discussed among interviewees of both states and was discussed within several themes -- perception, culture and environment, structures and support, role, outputs and impacts -- each of which are described below.

Perception

Perception as a theme in interview data had two streams: the relevance of perception during policy development and implementation, and perception of the office among implementers and their partners, policymakers, and the general public.

Interviewees discussed perception as related to policy development and implementation in three ways: 1) perception of what the problem is; 2) perception of what drives the

problem; and 3) perception of what the appropriate response to the problem. Most interviewees shared their perception of what racial and ethnic health disparities are and their causes. Participants in both states and across all positions believed that racial and ethnic health disparities are avoidable differences in health outcomes among different racial and ethnic groups.

Interviewees in both states shared their perceptions on what drives racial and ethnic health disparities, including individual and social factors. Individual factors included health behaviors among different populations; however, in both cases, these factors were discussed in the context of the social determinants of racial and ethnic health disparities.

For example, food and nutrition factors, such as accessibility to fresh foods, were discussed as a result of various racial and ethnic minority populations lacking healthy food outlets within their communities. Interviewees in both states also discussed health disparities as difference in health status between groups other than racial and ethnic groups, such as differences by socioeconomic status, immigration status or geography.

For instance, one interviewee highlighted that health disparities are going to exist because of differences in other factors:

When it comes to health disparities we're going to have them because as long as we have different populations that live at different economic levels, different communities, different cultures, different backgrounds, different beliefs and value systems, as long as we have that, there will be health disparities. – FL Partner

A few interviewees in both states shared their thoughts on how the general public viewed racial and ethnic health disparities in general. These interviewees perceived that the general public had a limited understanding of the factors related to racial and ethnic

health disparities, particularly on the social determinants of health. While the following interviewee, for example, believed that the general public does not understand the causes of racial and ethnic health disparities beyond personal behaviors, this interviewee also suggested that the office contributes to that lack of understanding:

There are some people who feel that a lot of the-- how can I say it? Some people think that people of color should be responsible for themselves, they should have better personal health habits, they should take care of themselves, and whatever differences fall out are just natural, and it will take years to overcome that difference. So there's a difference of opinion as to what makes it different with prostate cancer with black men versus white men, what makes it different with infant mortality. More black babies die than white babies. Is there a reason that more babies die? Is it diet? Is it exercise? Is it the mothers? Is it folic acid? So, I mean, there's a lot of debate about why do we have health disparities, and one of the purposes of the Office of Minority Health is to try to pursue it and find out why. And we haven't done that very well. –FL Administrator

In addition to discussing perceptions related to the nature and causes of racial and ethnic health disparities, interviewees also shared their thoughts on how their respective office was perceived among various stakeholders. Although this issue of perception among stakeholders had a few commonalities, it was generally discussed differently across the two states.

Most FL interviewees believed that the OMH was not viewed favorably among the general public and many state policymakers, and some indicated that the office was not perceived favorably in their personal views. Interviewees did, however, perceive that the OMH has had some successes and those successes were generally viewed favorably among grantees and community organizations. There were some aspects of the FL OMH that were not viewed favorably among some participants, and these perceptions were

driven by personal experiences with the FL OMH. One grantee organization described being dissatisfied with the evaluation methods the FL OMH chose to implement, along with the frequent changes in measurement and evaluation methods the OMH expected grantees to use.

The difficult piece has been really focused around the minutia and the red tape of dealing with the state and dealing with-- I will tell you there was a period of time when literally every year, every other year, we had a new evaluation system that we then had to feed into. And it was ridiculous. Like I said, you never knew who was on first. Our databases were always changing. The provider who handled the database or what information they want collected wasn't even consistent from year to year to year, when they want us to go back and then put out an organization. –FL Partner

Another perception related to the FL OMH focused on communication and outreach. A few interviewees noted that there was limited communication flowing from the office to the broader community, suggesting a disconnection between the OMH and broader health disparities community. A few FL partner and administrative interviewees were unsure about what the office is currently doing due to a lack of communication. For example, one interviewee noted that they believed that the office was currently unresponsive:

Well, I think what contributes is whether or not that office responds to anything you're doing. And this has been my problem. The office has not been doing very much. It's very low-key, it's very undertoned and it's very unresponsive. –FL Administrator

Some FL interviewees discussed how perception impacted the experience of implementation. For example, a few interviewees in FL suggested that some viewed the office as not an office for minority health in general, but as an organization focused only on Black health. This perception may have limited the appeal of the office to broader

populations; thus, decreasing support and resources available to the office. One interviewee described this perception among the general public:

Oh, I've actually had people call and say, "Why do," you know, there's quotes in the paper, and most papers, newspapers online now have the Comment section, and you can just read people saying, "Why do we need an Office just for black people," because many people still think that minorities are specifically for black people or people of color and they don't include things like hearing impairment, vision impairment, any of the disabilities, they are not included in minority health. They also don't see that minorities can be white, as well, if they're economically disadvantaged. –FL Administrator

Although FL interviewees had some negative perceptions of the FL OMH, some interviewees acknowledged these perceptions in the context of some of the office's challenges. For example, one FL partner noted that given the limited resources, the office was doing the best that they could with what they had. Another FL partner suggested that the office had some negative perceptions in the past, but that they were doing better now.

In MD, interviewees viewed the office positively, and believed that the office was also viewed favorably among legislators and the public. This view was shared among both administrators and community partners, and resulted from the organizational structure and position of the MD MHHD. The organizational structure, such as having a standalone office focused on minority health and health disparities, is not always the case throughout the U.S., as one interviewee noted:

And I tell you, in other states... Maryland is fortunate. One thing that I learned being at the federal level, usually an Office of Minority Health, when you hear that in other states, it's one person. One person, and they're, like, a program manager or something like that or it's not an office. When I came here and realized like, "Wow. There's actually staff." Or it's an office that's assumed under another office. So it's more so an initiative or something within a bigger office, so to speak. But it was nice to come to Maryland and to realize, "Man, you

are a stand-alone office in the Office of the Secretary, and you are recognized with a real staff to be able to address these issues.” –MD Administrator

A few MD interviewees also suggested that the staffing resources within the MHHD contributed to the positive perception of the office. A couple of interviewees stated that although the staff is small compared to other offices within the state department of health, the MHHD staff is larger than OMHs in other states. With that staff, the office is able to accomplish much and respond to constituent needs, and maintain an active presence throughout the state. However, as the same interviewee as above noted, there are challenges to this positive perception, including being overwhelmed with requests:

So as far as the major challenges go, it’s just that I think we, when people remember that we’re here, sometimes it becomes slightly overwhelming because we are so small. And so when different projects or legislation or whatever passes, especially if it has to do with minorities, it’s, “Oh, well, let’s move this over to the Office of Minority Health. Let’s get the Office of Minority Health in on this to provide advice or guidance on different...So that type of stuff becomes a little overwhelming, because we just get stretched so thin. We’re small. –MD Administrator

Culture and Environment

Culture and environment was a theme discussed by interviewees as a factor in policy development and implementation. Several aspects of culture and environment were discussed, including legislative and political culture, administrative culture, and broader social and economic environments.

The political environment in FL was discussed as a barrier to both office implementation and health disparities policymaking. Interviewees described a key political barrier -- the

political leadership within the state legislature, particularly the impacts of having Republican dominance in the policymaking process. In addition to the political culture as one focusing on fiscal issues, a few interviewees connected Republican Party control over the last few years with an increased emphasis on smaller government and government accountability served as a barrier to FL OMH implementation.

Another factor related to the political culture and environment in FL was the impacts of that culture on office implementation. One impact a few FL interviewees discussed was on OMH leadership. These interviewees focused on how changes in the political environment related to the high turnover rate of the FL OMH directors. As one partner interviewee noted, high turnover of the FL OMH directors was an issue that local partners had to learn to live with; however, as the following quote shows, that turnover had to be considered within the broader political context within FL, not just with the FL OMH.

It's obviously an issue. But, I guess, what I want to say is I don't think it's a deal breaker. I mean it is what it is. I think the broader context-- I mean you can't just look at that office. You have to look at the whole political climate in Florida. –FL Partner

The lack of support for certain bills across both houses of the state legislature was another political barrier FL interviewees discussed. This lack of support meant that bills were not moved out of committee and onto the legislative floor after their introduction. In addition to bills needing to move out of committee and onto the floor for advancement, as previously mentioned, bills introduced in the House need a Senate sponsor as well.

Most of the reason why they "failed" is because they were never picked up and brought to the floor. A couple years, it was a situation in which maybe the Senate put one in but the House didn't. So, when we actually had an opportunity on both sides and the legislature actually put forth a bill, it never got to the floor. Part of it was, "Oh, well, we're, you know, busy dealing with this issue," or, you know, something "more important" came up. And that really wraps itself all around what I was speaking to earlier in terms of funding for the Office. –FL Administrator

In MD, the political culture was discussed positively overall. Interviewees discussed the political culture in respect to supporting the MHHD and as it related to developing new health disparities legislation in general. A few MD interviewees acknowledged that there was always some political opposition to health disparities legislation. One interviewee suggested that the political opposition resulted in fewer substantial health disparities legislation over the last few years (2012-2013) in MD in favor of legislation fostering collaboration and workgroups.

In both states, interviewees discussed the role the overall economy plays in the implementation of their respective offices, particularly funding. A few interviewees from both states noted the impact of the 2008 recession on how the state legislature dealt with funding for their offices and for health disparities legislation. One MD interviewee felt that the because of financial cutbacks by the state legislature during the recession, the number of health disparities legislation declined, and when such legislation was passed, it tended to be through unfunded mandates.

Structure and Support

Perception of the problem, its causes, and appropriate policy responses tied with culture and environment combine to lead to the creation of structures and support to address racial and ethnic health disparities through state OMHs. Structure, as discussed by interviewees, focused on the organization of the office, such as its organizational placement and mandates or regulations structuring the office's activities and implementation. Interviewees discussed structure in terms of the enabling legislation, organizational structure, and support, such as funding, human resources, and political and administrative will. Interviewees discussed how support resulted from buy-in among different actors, such as legislators, administrators, and local communities, and included administrative, human resources, funding, and political support.

Perceived Support

As previously noted, interviewees perceived that their respective state legislatures created OMHs within their state because policymakers saw the need for specific infrastructure to eliminate racial and ethnic health disparities. While interviewees in both states shared this perspective, FL interviewees discussed support for the FL OMH in a way suggesting that support for that office was not as strong as support found in MD. For instance, MD interviewees tended to view that while more funding could be used, the office generally had support and respect among administrative and political leadership. For example, one interviewee noted that the MD MHHD was in the forefront of public health

administration, noting that the office was not treated as an afterthought or as something that existed only in title.

I mean, I think this office gets just the respect. And it's noticed, it's there. It's not something that's just kind of in the background like, "Oh, yeah. We do that minority thing too." It's an actual office. Like, it's an actual something that exists. I think in the other states, again, you have one person who might be focusing on it for an entire state. Or <laughs> in some cases, it was like their Office of Women's Health was the Office of Minority Health. But that's clearly not the same. Sometimes a title of something really speaks volume as to how you consider or how the office is viewed. –MD Administrator

In FL, most interviewees focused on the lack of funding support for the OMH. In FL, some of the funding challenges were also discussed in terms of the statute creating the Office. A few interviewees described the challenge of funding as not being enough, but also subject to the political environment of the state. As described by those respondents, the limited language of the statute makes the office vulnerable to changes in funding, especially if funding has to be provided to the office. Two interviewees discussed the impact of legislative language on OMH implementation:

As long as you don't have a defined definition of what the duties of the Office is, you don't have the funding. And so, some of that is definitely a political game, absolutely. –FL Administrator

The FL partner quoted above continued on to describe how in addition to the legislation lacking a mandate on funding, the perception that society is now “post-racial” among policymakers also impacts funding. The interviewee stated that this perception leads to a belief that they “can shift those dollars somewhere else,” away from the FL OMH.

Structure and Human Resources

One aspect related to structure and support is the human resources within both state offices. The level of staffing for the offices was not included in either state's enabling legislation, although the MD statute does mandate a director, including their roles and duties. While the level of staffing was also not listed on each office's website, MD interviewees agreed that the office included about 12 staff. FL interviewees suggested that the FL office included approximately eight staff members.

Participants across states and positions also discussed the role of personal attributes among those implementing OMHs. Passion for eliminating health disparities and improving minority health was cited among a few interviewees in both states as a factor positively impacting OMH implementation.

Another personal attribute discussed among a few participants relating to OMH implementation is previous work and training. A few interviewees discussed training of personnel within the office as a factor in OMH implementation. One MD administrator discussed how their doctoral training and nursing background shaped their office management practices. Another interviewee focused on how employees in some state OMHs, and state health departments in general, lack strong training in data collection and analysis, which could influence the quality of data the Office produced and presented to administrators, legislators, advocates, and the general public.

One interviewee cited her past experience as a federal employee working with state OMHs as a factor in how they approached the implementation of MHHD in MD. A couple of FL interviewees also mentioned their past work in public health as a factor in their understanding of how the office should be implemented. In both states, interviewees' understanding of the drivers of racial and ethnic health disparities also influenced their approach to the implementation of their respective offices. For example, most interviewees believed that racial and ethnic health disparities were partially driven by social factors. Therefore, these interviewees discussed how this perspective on the causes of disparities influenced who they sought out for partnerships, including health and non-health related stakeholders.

Political and Administrative Support

Most MD interviewees acknowledged that the office had both political and administrative support. One way the office was supported among the broader health department administration was through the encouragement of collaboration between the office and other departments within the agency by the Secretary of the state department of health.

The—[Secretary] is working very hard on connecting a lot of programs in the department which needs to be collected because too often departments like this across the country are siloed by-- not that people want it that way, but they get bogged down in their own program or unit because they have so much to do. There's very little time to look up and out to see who else is doing something similar, and oft times, there's a lack of kind of collaboration and connection. So we are focusing on how we can be connected to all the other programs in the department. —MD Administrator

Interviewees also described office sustainability in FL in relation to the political culture of the state. Although the office is mandated by statute, a few interviewees described the lack of ability of the statute to protect the structure of the office. For example, those interviewees discussed attempts to move the office from a standalone office to be subsumed under another department. While the statute mandates an office, it does not mandate where within the department the office should be or if the office should be funded.

A few Maryland respondents understood the role of legislation and funding in office sustainability. Although respondents did not feel that the sustainability of MD MHHD is threatened, one respondent described their perceptions of how other states were threatened by a lack of sustainability. The interviewees' perceptions aligned with how FL interviewees described their experiences and perceptions of the sustainability of the FL OMH. For example:

I think the strategic placement of this office, the fact that our office is placed in the Office of the Secretary shows the value to the department that we are a trusted source to the secretary on addressing health issues, specifically minority issues, which means when you look at us on the organization chart, anything minority health related should really be coming to our office, you know, to get that guidance. I don't think the other states are set up that way. And in fact, when I was working at the federal level, there were several states whose offices were being threatened to just be abolished altogether because the state didn't see a need for it anymore. Or they felt like it was a program that could be assumed into something else, so it no longer would've been an office of something, it just would've been a special initiative within another office. So I feel like Maryland has the stability as an office that doesn't exist in majority of the other states. Thing [is that] a majority of the other states from year to year worry that their office isn't going to be there anymore. –MD Administrator

MD interviewees believed that the MHHD would be sustained. One reason for this belief given by a couple of MD interviewees was because the office was written into state legislation. Another reason cited among a few MD interviewees was that because the office has had positive impacts and does have a designated role throughout the state, the office would be sustained. Although MD interviewees generally perceived that the office would be sustained, a couple of interviewees suggested that one threat to sustainability was the funding structure. One administrator noted that the office was funded by both state and federal funds, some of which is not guaranteed each year; thus, if some funds were lost, there would be a real and immediate impact on both staffing and programming.

So for instance if we lose state funds or federal funds we potentially lose two position and partial short at an instant. So we would lose some of our key activities that we have been working on.

–MD Administrator

While MD respondents did not perceive a threat to their sustainability or existence, they felt that other states operate in an environment where the threat is persistent and real. This threat to sustainability was prevalent among most FL interviewees. Those FL interviewees described this threat as one due to funding, political culture, and perception of the office.

Interviewees also acknowledged that sustainability of the office is being supported by increased recognition and awareness of minority health and health disparities throughout their respective states. For example, interviewees in MD discussed the role of recognition of health disparities among legislators, which may have factored into the expansion of the diseases the office targets. In FL, the recognition of health disparities and minority health

issues by administrators, community partners, and legislators may have helped the office maintain its existence.

Increased recognition may not always be a protective factor in the sustainability of the office. Despite increased recognition in both states, office funding has decreased over time. Some interviewees suggest that broader, external issues may be a greater influence on office sustainability than increased recognition among the public and policymakers.

Roles

The theme of roles was discussed in terms of interviewees' perspectives of what the purpose of the Office is, the activities they do, and what guides the activities. How implementers understood the enabling legislation influenced how they discussed implementation of their respective offices and the roles their office play.

Interviewees in both states discussed the main role of their respective office as one focused on improving the health of racial and ethnic minority populations within the state. While minority health issues were in the realm of the office, and in the case of MD, mandated by state legislation, some interviewees acknowledged that other offices within the state health department also addressed racial and ethnic health disparities and minority health issues. This reality has consequences for funding, such as another department besides the OMH receiving funding for minority health. For example, one MD administrator noted:

You know, the office who works in, say, child and maternal health. They apply for those type of funding. If you have an office that works on influenza we have an immunization program. They apply for those programs. So we just can't go and apply for everything that our heart desires, although if you look at our legislation it said that we would serve as a point of contact for funding the focus on health disparities, but that doesn't always pan out that way.

–MD Administrator

In FL, the understanding of the policy of creating a state OMH varied while in Maryland, interview data showed that there is clear understanding of the policy. For example, interviewees discussed the role of the Florida OMH in the context of CTG grant administration. One interviewee, a former OMH administrator, spoke of the OMH as if its identity lay in CTG. For example, when asked about the health disparities issues OMH decides to focus on, the interviewee responded by describing the issue areas mandated from the CTG legislation.

Well, there was a misnomer there, because if you read the legislation that put the Office together, and I want to say it's Florida Statute 3758, it really does have language about what the Office is supposed to do. It doesn't define, you know, whether or not they need to have a Director and an Assistant Director, but if our job is to put out these grants, they obviously have to have enough staff that's able to do that, at a minimum and to also manage those grants once they are out there and provide for the funding and things. So, there's definitely language in there that would allow the Office-- though, too, at this point, I don't think there was any leadership of our state, choose to, to really provide for what the Office can do and should be doing. Again, it doesn't go into details or the duties, but it absolutely does have enough language that would specify what the Office should be doing. –
FL Administrator

Most FL participants acknowledged the other roles of the FL OMH outside of CTG, but framed their overall understanding of the policy behind the OMH in terms of CTG. Some Florida interviewees agreed with the view that if the CTG program was defunded or discontinued, they were unsure if the OMH would still exist:

What does it do? Right now really if you take a look at it, the Office of Minority Health staff is there to administer the Closing the Gap grant. If the Closing the Gap grant, if the legislation defunded that, then there would be no reason at least currently for it to exist. –FL Partner

In MD, administrative participants framed their discussion of office in terms of the mandates within the state legislation creating the office. Discussion about the role of the office, activities, and office outputs were discussed in terms of what the statute mandates, such as education and awareness activities, grant-making criteria, and technical assistance. For example, one MD participant referenced the statute as the foundation of deciding how the office should approach its mission of eliminating racial and ethnic health disparities:

The office is established in statute in 2004, and it has a number of functions-- actually, 21 listed in the statute that the office should undertake in an effort to promote the elimination of racial and ethnic health disparities in the state both in government programs and in private sector programs... Essentially, I set the office up using the statute as a guide and aligned the functions with-- that's what we do. –MD Administrator

Study participants also shared their understanding of the policies creating their respective offices by discussing who is targeted by the OMH implementation activities. Participants in both states focused on non-White and Hispanic populations, such as African Americans, Native Americans, Asian Americans, and Latinos. While the statute creating the FL OMH does not specify who the target populations are for the OMH, study participants indicated that the target populations included the non-White, Hispanic communities. In MD, study participants agreed with the target population of the Office's efforts; however, the discussion about target population related to the statute creating

MHHD. The statute defines “minority person” as “African Americans, Hispanics, Asian and Pacific Islanders, and American Indians statewide” (MD Code Annotated §20-1001).

Partner interviewees in both states acknowledged both the target populations of their respective OMHs and of their community organizations. For example, partner interviewees agreed that the target populations of their state OMHs were all racial and ethnic minorities, but also acknowledged that their community organization might focus on all racial and ethnic population groups, or just a particular subset of a racial or ethnic group.

Most interviewees in both states also discussed the role of state OMHs in creating and maintaining partnerships and relationships. The main partnership discussed among interviewees was that of the grantor-grantee relationship between the state OMH and its local grantees. These discussions were consistent with how both of the offices were described on their respective websites, such as the activities conducted in community outreach and health education.

Results of OMH Development and Implementation

Interviewees discussed the results of OMH development and implementation through their respective office’s outputs and perceived impacts of those outputs. Results were discussed at three levels: legislative, organizational, and community.

Legislative results focused on increasing awareness and understanding of racial and ethnic health disparities among state policymakers in both cases. A few interviewees in both states suggested that one important impact of the implementation of their respective office is that legislators are more aware of the extent of racial and ethnic health disparities within the state, as well as their causes. For example, one MD administrator described how, over time, the Secretary of the Department of Health began to increasingly speak about racial and ethnic health disparities in his remarks, raising awareness of racial and ethnic health disparities throughout the state.

Relatedly, some interviewees in MD discussed this impact on policymakers in terms of building a brand for the MHHD and its MOTA program. This included ensuring that policymakers were aware of the MOTA program and the office in their respective districts, and that they were invited to participate in a program event to connect with the MOTA grantee and the populations they serve. Although it was clear that MOTA grantees were encouraged and made efforts to connect with their state legislator, and grantees understood the importance of that connection, some legislators were not receptive to their invitations to connect. Regardless of a lack of direct legislator participation, these efforts created a MOTA brand, allowing for increased awareness and visibility of the program among state policymakers across MD.

Now, of course, programs cannot lobby. When you receive state funding, [you] shouldn't be lobbying. But they keep their legislators educated and informed, and we help them do that. So for instance, we provide them information that they can share with their legislators about different stats and things like that, just to keep them educated. –MD Administrator

Interviewees in both states discussed some general office impacts and successes. No interviewee identified only one success or impact of their respective state OMH, but rather discussed impacts in groups. For example, interviewees across both states and all three positions tended to discuss OMH success as a group of impacts, rather than one singular impact, which is highlighted by this quote:

I think it would be hard to say it's this one. I think that they've done a lot in cancer. They've done a lot with data. They've done a lot on infant mortality. They've done a lot with helping us set up the Health Enterprise Zones. I think it's more a string of accomplishments. The primer on cultural linguistic competence was very important too. –MD Administrator

Some administrators in MD discussed office impacts and successes more specifically. This included discussing programs that demonstrated reductions in health disparities, such as decreasing tobacco use. As shown below, one MD administrator focused on the office's grant program's impact on infant mortality:

So, I think almost going back two years ago, I believe, we were able to see that there was a significant difference for infant mortality, at least in Prince George's County. And, that was an area that some people had said you'll never be effective in doing anything in that jurisdiction because it's big, it's too much fragmentation, but we did and we felt that it made an impact because that was the only county that you could see a statistical difference of improvement. –MD Administrator

Community impacts of the implementation of the state OMHs focused on increasing awareness and visibility of racial and ethnic health disparities among stakeholders and community members, connecting local actors working on health disparities across the state, programming, capacity building, sustainability among community organizations, and funding through their respective grant programs.

Through the grant programs in both states, the OMHs supported programs that provided opportunities for local collaboration on racial and ethnic health disparities. This collaboration included connecting with other actors related to public health, as well as with actors not specifically focused on public health. For example, as one FL partner noted in the following quote, the grant program enabled their organization to connect with local actors associated with the social determinants of health, such as housing, transportation, and economic development.

Well, it did for me because, I mean, I-- we started having conversations more with the transportation-- it's the Pinellas-- what is--PSTA. I forget what that stands for-- Transit Authority of Pinellas-- housing, working with folks in housing, looking at working with other organizations who are advocating for economic development in those pockets of poverty-- so partnering with them and, of course, being a state entity, we can't go out being advocates, but we did partner with folks who could go out and be advocates, and then lobby their legislators. So that was the-- for me, was the shift-- really working more closely with those entities. –FL Partner

Interviewees in both states and across positions discussed capacity building and sustainability as an impact of the implementation of the state OMHs. These capacity building and sustainability impacts focused on ensuring that local community organizations were able to sustain health disparities efforts after the grant period ended. Efforts to sustain the program beyond the funding period included providing technical assistance to local organizations to build organizational infrastructure essential for sustainability, such as the ability to apply for additional grants or improving budget and accounting practices.

One MD administrator described the need for capacity building among local organizations as a result of some grantee organizations never being previously involved in state programs. Because of that, such organizations lacked infrastructure necessary for budget reporting and tracking needed to participate in state programs. When this type of infrastructure need existed among an organization, the MD MHHD worked with them to build their capacity to meet that need. FL interviewees, including both administrators and partners, also discussed similar local efforts to increase organizational sustainability:

So, helping them understand how to grant write. Some of their things that I know I tried to do with them was to help them understand how to do the paperwork, administrative side of things, so that they could, you know, function. Beyond that, how to do invoicing, how to make sure you are thinking holistically about what your agency can do. Some of them really didn't understand the need to not necessarily chase funding, but to look for things that really-- and so when they'd have a grant-writing class for them, to look for things that fit with what they were already doing, those type of things. –FL Administrator

Capacity building was also a result of grant requirements. One such requirement in MD involved human resources, such as hiring community members with the same race and ethnicity as members of the target group. These community members included community navigators or community health workers. The grant requirement also mandated that the grantee organization hire community members (i.e., lay health workers) to conduct health outreach. These target hires would have limited formal education, such as high school diplomas or equivalent and would not be trained social workers, licensed nurses, or other health professionals.

The purpose of the community health worker approach, as described by one MD administrator, was to promote the use of a model or framework driven by the community

rather than medical training. This approach allowed for community issues and understanding to rise, rather than a top-down, “we tell you what you need” approach. The community members participating in grantee programs were not limited to adults; in both states, partner interviewees discussed using youth as peer health promoters and for community outreach. Including youth was a strategy that resulted in building youth capacity and interest in racial and ethnic health disparities, which was believed to then spread among their peers.

Well they learn what is diabetes, they learn what is cardiovascular disease, they turn around and talk to their own people. So we're looking into young, I call them youth advocates, so we hope that we can develop more through the MOTA program. –MD Partner

So we're in the process of implementing and we're trying to wait to see if we can - we even applied for a grant from the office of minority health to support a project that we started in 2011 where our young people will now be trained as advocates in their schools so that they can promote awareness in the areas that are most effecting them, that can lead to other things and exposures and issues. So, for example, we have a team of young people all ready trained at Gainesville High School and these young people are going to now be trained to help us link their peers to the support services that teens are not even aware of. –FL Partner

One perceived impact at the community level that was discussed by interviewees across both states was connecting various actors at the local level who were focused on addressing racial and ethnic health disparities. Often, different organizations focused on community health and health disparities were working individually, resulting in duplicative efforts. Interviewees described the connection of various actors to address racial and ethnic health disparities as a positive impact because it provided opportunities for collaboration and partnerships. For example, as the quote below shows, connecting people across the state helped people feel less like they were working alone:

I think one key thing that did happen at the state level is the-- creating the minority health liaisons for each county. I think that linked at least within the state. It linked folks together to find out what are you doing in your county, so I think that was a very good and smart move, but, of course, I'm not a part of that anymore. But I think that was a really innovative thing to do. I mean, maybe other states are doing it, but, for here, it seems rather innovative to do because you didn't feel like you were functioning in a silo. You had folks you could reach out to, and you knew who that minority health liaison contact was in another county.
–FL Partner

Another FL interviewee echoed this sentiment, noting that the creation of minority health liaisons brought individuals together, resulting in shared information and resources.

And one of the things they've done, again, that's very positive that in most of the counties there is a health disparities liaison. And those individuals come together. They have conference calls. They communicate. They share information, share resources. And I don't know if we can say what the outcomes are of that but you can say that's a best practice. –FL Partner

Although FL interviewees agreed that minority health liaisons and having a sense of connectedness and collaboration was positive, one interviewee, a former minority health liaison, noted a major drawback. Minority health liaisons are appointed to serve as liaisons by the local health department. However, while there are expectations and duties that the liaison must fulfill in addition to their regular job duties, liaisons were not funded and did not come with extra resources. Thus, some may view serving as a liaison as extra work without the needed resources to fulfill both the liaison duties and their regular job expectations:

The local county health directors appointed-- they were tasked with appointing someone from their county health department to be on this network that they built and they asked me to do it. So I did it. I did it to the best of my ability but it was extra work. - FL Partner

While MD did not have a specific position similar to the Minority Health Liaisons in FL, interviewees did discuss the OMH as having a similar impact in terms of increasing collaboration by connecting those working on health disparities at the local level through community coalitions. Additionally, minority health liaisons in FL were government employees; however, community coalitions in MD focused on connecting community organizations and residents to others working on health disparities.

We also had-- have in their logic model that there should be a community-- what am I calling it-- community coalition because it's our theory that you cannot work in these programs in isolation-- that you need to have some of the recipients of the program and the different providers as a part of a team, so they understand what's going on, and they also can contribute because no one-- just like no one person in a office or a team can do the whole job. No one individual in our community-- it's-- it just-- it's a community of people working on the same issue.
—MD Administrator

Some administrative and partner interviewees in both states also discussed some challenges they face while working with local communities. The main challenge described was building trust within the targeted communities. Some administrators discussed overcoming the challenge of trust by making concentrated efforts to get involved, such as making it a priority to attend their local events.

I think the most important thing when it comes to working with community groups is that you get them to trust you. They have to feel like you're not just the state who's coming in, trying to tell them what to do, throwing them a little bit of money, and then that's it. You have to kind of get involved and show that you care. So I try to really make it a point of attending their activities when I can. If they're in the morning, if they're late at night, if they're on the weekends. I really try to make a point to make it to it. If I've got to drag my child with [me], we're going, you know. —MD Administrator

Establishing trust was also discussed among a few interviewees as something that should be considered and worked on from the beginning of community partnerships. There are several results from establishing trust from the beginning, such as continued partnerships and interest in working with the state office, or community buy-in, which is an important aspect of sustaining partnerships between the state office and local organizations. One of the interviewees described the impacts of building trust upfront:

So if I can engage you from the beginning, show you the value of this, how it's going to help serve the same people that you want to help and that you want impact, then people are going to buy into that. If you've been with me at the beginning, then we're more likely to be there at the end because you're invested. And so if I tell you I value your opinion from the very beginning, then you're going to trust me that I'm going to do and value your opinion till the very end. It doesn't happen overnight. –FL Partner

A few participants indicated that because they have been involved and are visible in the community for some time, trust was no longer an issue. Even though trust was no longer an issue, it does not mean that it would remain that way. As one FL partner who was interviewed described it, community trust is an ongoing process and takes time to establish and maintain:

It's about relationship building. Relationships are built on trust and trust happens in more than just a one-time session. – FL Partner

One aspect of attempting to build trust in the community is ensuring that the community benefits from any research conducted, especially among university partners. Some interviewees discussed a history of community interventions focused on research with limited direct benefits to the community. This history, as discussed particularly by FL interviewees, could lead to mistrust and a lack of willingness to support state office

initiatives. One FL partner interviewee described a method they used to build and maintain trust when it came to conducting grant programs that included a research aspect. This method focused on ensuring that whenever the researchers would interact with the community, the partner would make sure they were also present, acting as trust broker between the researchers and the community, as shown by the following quote:

And I don't feel challenged with trust because I've been in the community a lot but I hear that going on a lot throughout the state, like even if a researcher comes in and they're coming in with me. –FL Partner

Several FL interviewees perceived that while the state OMH had some impacts and successes, state OMH was overall not successfully implemented. The quote below shows how one interviewee perceived that the FL OMH was not successfully implemented because the impacts of the office did not meet the expectations of those who created it:

I would have to say that it has not been as successful as those who put it in place expected it to be because I'm not seeing the level of reduction in disparities that we would have thought we would have had if we were truly focusing on minority health disparities and making improvements. –FL Legislator

Some FL interviewees noted that they were unaware of the current state of the state OMH. While interviewees are aware that the OMH still exists, a lack of broader communication from the OMH to actors outside of their grantee and other direct partners lead to limited understanding of the current status of the state office.

So I don't know where it is going. I do not know what the future holds. Is it going to be policy, is it going to be regulatory, is it going to be informational, is it going to be communications? I mean, you just don't know where that office is going. –FL Administrator

Some interviewees from both states discussed the successes of OMH's partners rather than those of the OMH itself. The common success for the local level that was cited among these interviewees was programming; however, this perception was described with some challenges the local organizations faced, such as funding and other support from the state office, particularly in FL. As one interviewee, referring to the programs conducted by local community organizations, noted:

At the end of the day, I think they did do some great programs. I think we did some great programs along with other partners around the city, did some great programming. I just don't think they had the support from them that they needed.
–FL Partner

Due to the local level programming that was achieved with state OMH grants, one interviewee noted that an impact the state OMH had among local communities was increasing recognition and awareness of local work addressing racial and ethnic health disparities. While most interviewees across both states talked about the role of community organizations in state OMH implementation, this interviewee specifically highlighted that important role, suggesting that without the local efforts, state OMH implementation would be limited.

You know, the little bit of funding that we're giving them, it's only a little bit. But they give so much credit and reference back to our office for helping them and guiding them and just showing an interest in what they actually do. So for me, I feel like our biggest accomplishments is when our local programs get their recognition and get their accomplishments. Because, honestly, if it weren't for them, they're the ones out there on the ground doing the work. If they weren't the ones out there on the ground doing the work, we would have nothing to report. – MD Administrator

Some FL interviewees talked about what successful OMH implementation would look like to them. Elements of a successful state OMH in FL included strong leadership within

the state OMH, an office that was fully supported through staff and funding, and an office that had capabilities to make tangible impacts on racial and ethnic health disparities.

Successful is one of those terms that's difficult to pin down. I would, in our state at this point in time, think that success would look like having an office that was fully able to function autonomously and really have a say into where are health disparities, how and why. It would be one that, again, is collecting data that would allow us to really do something about the data we collected. –FL Administrator

SUMMARY

Results from the three study aims were presented in this chapter. Aim 1 findings demonstrate that from 2002-2011 states used their legislative powers to address various health disparities topics through legislation, especially building health disparities-related infrastructure, appropriations, and disease-specific legislation. Findings from Aims 2 and 3 suggest different factors influencing health disparities policy development and the implementation of state OMHs. Among those factors, the most common focused on political culture and environment, structure and support, and perceptions. These findings also illustrate OMH outputs and impacts, including impacts on awareness and local capacity building and sustainability. Finally, these results illustrate the various roles that some state OMHs play, including public educator, collaborator, and connector.

The next chapter provides a discussion of these results, in the context of the existing peer reviewed literature and the conceptual model that guided this work. The chapter also discusses the policy implications of these results and offer recommendations for future research directions, as well as study strengths and limitations.

CHAPTER 5

DISCUSSION AND POLICY IMPLICATIONS

The purpose of this study was to examine the racial and ethnic health disparities bills and legislation across all 50 states between 2002 and 2011. This research also sought to describe how one policy approach commonly used to address these health disparities, the creation of state OMHs, was developed and implemented in two states. This study was guided by three aims, and generated new and interesting data that makes a significant contribution to the existing literature regarding racial and ethnic health disparities legislation, policy development and implementation, and state OMHs.

This Chapter is presented in three sections. First, I will briefly summarize the study findings. Second, I will discuss these findings in context of the current literature and provide policy implications of these results. Finally, I will present areas for future research and conclude with the strengths and limitations of this study.

SUMMARY OF STUDY RESULTS

Aim 1: Mapping Proposed and Enacted State Legislation

The legal review conducted for this dissertation revealed that most states used legislation to address a variety of health disparities topics during the study period. Introduced bills primarily focused on three topics: infrastructure, such as creating OMHs and establishing

task forces; appropriations for health disparities-related programs; and specific diseases. Among infrastructure bills, creating state OMHs was the most common policy strategy. Other topics included race-specific initiatives; requirements for data collection, reporting, and planning; research studies; health disparities recognition/awareness; diversity within the public health workforce; and cultural competency.

Over half of the analyzed bills successfully passed (54.4%). Bills targeting certain topics were more successful than others, such as recognition/awareness (72.4% passage rate), appropriations (67.6%), and representation bills (56.5% passage rate). The lowest passage rates by topic were between 36-49%. Thus, when racial and ethnic health disparities bills were introduced between 2002 and 2011, they were successful at least one-third of the time.

The findings from Aim 1 suggest that, on average, states that introduced more health disparities bills also addressed more than the average number of health disparities topics (6.1 topics). In general, states that introduced fewer than the average number of bills (13.1 bills) may have decided to focus on a set of particular policy topics; however, two states that proposed more than the average number of bills addressed fewer than five topics.

Aims 2 and 3: Developing and Implementing State OMHs

Findings from Aims 2 and 3 were from two case states, Maryland (MD) and Florida (FL), and illustrate factors that influenced health disparities policy development and OMH implementation, as well as perceived impacts of state OMH implementation.

When discussing policy development, interviewees from both states did not focus much on the policy process that created their respective state OMH; however, interviewees did discuss factors related to developing health disparities legislation more generally. For example, interviewees described using public health data specific to demonstrating trends in racial and ethnic health disparities at the state and local levels, and having legislative support as having an impact in health disparities policy development. The legislative support interviewees described occurred through policy entrepreneurs and interest groups. Participants also described how health disparities were framed, such as the trend towards using the term “health equity” rather than “health disparities” or “minority health” in legislation and in data collection.

Across both states, interviewees discussed the implementation of their state OMH within five main themes: perception, culture and environment, structures and support, role, and outputs and impacts. Perception focused on how the Office was perceived by individuals external to the agency, such as OMH partners, academics, and legislators, and how interviewees understood the policy creating their respective Offices. Because the MD policy included clear mandates that guided implementation, interviewees from this state understood the policy driving the implementation of the Office as such. This was not the case in FL. These interviewees tended to discuss OMH implementation in terms of the

policy creating and framing the Closing the Gap (CTG) grant program. These differences in perceptions may be because the policy creating the state OMH in FL was severely limited to one line, and did not include mandates that could influence the implementation of the Office, as was the case in MD.

The theme of perception also illustrated how interviewees perceived the nature and causes of racial and ethnic health disparities. Generally, interviewees in both states viewed racial and ethnic health disparities as unequal health outcomes, mainly driven by social and economic factors. While some interviewees described these factors specifically as social determinants of health, others described social and economic factors contributing to racial and ethnic health disparities that were persistent with the theories of the social determinants of health, but did not use the term.

Culture and environment were discussed in reference to the political and administrative culture within the state. While interviewees in FL discussed a culture and environment that negatively impacted and limited OMH implementation, MD interviewees believed that the political and administrative environments were not barriers to implementation. Both state Offices were written into legislation and were standalone offices within the state health department; however, FL interviewees described a lack of administrative and political support, whereas MD interviewees described having positive administrative support and the political will to act on different racial and ethnic health disparities initiatives. Because of the perceived lack of support, the sustainability of the FL Office was more vulnerable than the MD Office; indeed, FL interviewees were unsure of the

direction of the Office or what would happen if the state legislature decided to cut the CTG grant that the Office administers.

Interviewees in both states described the Offices as having similar roles. These roles include grant-making, increasing awareness of racial and ethnic health disparities at the local and state levels, and education-based outreach activities. Some grant-making activities included increasing awareness and providing education-based outreach, as well as connecting communities to health services. While both state OMHs also acted as a collaborator and connector, MD interviewees described this role in a way that suggested a deeper and broader reach and impact than FL. Some of the outputs and impacts described by interviewees were similar across both states, such as increasing legislative awareness of racial and ethnic health disparities, improving local community organizational capacity and sustainability, and introducing youth to health disparities and training them to be peer educators.

Challenges to OMH implementation were revealed for each of these five themes.

Interviewees from both states discussed challenges related to funding and staffing. For example, funding for both state OMHs include state and federal sources that are not necessarily guaranteed each year. Staffing was also described in the context of funding, in that interviewees noted that staffing was vulnerable to funding changes. Interviewees in both states also discussed the need for more staffing for grant-making and programmatic roles. These interviewees also noted that passion played an important role in attracting and promoting staff to work in or with the Office. Sustainability and political

and administrative environments were also mentioned as challenges, but only in the FL case.

The remainder of this Chapter puts these highlighted results in the context of the existing peer-reviewed literature related to policy development, implementation, evaluation, and health disparities legislation, and describes the policy and research implications of the study findings.

POLICY DEVELOPMENT AND IMPLEMENTATION

Previous research shows that policy development and implementation are impacted by a variety of factors. These factors include data and information, framing, policy preferences, and policy entrepreneurs, among others (Durlak & DuPre, 2008; Hill & Hupe, 2002). This section focuses on those factors as illustrated by the study results as influences in policy development and implementation, such as health disparities data, framing and understanding of policy problems and racial and ethnic health disparities. This section also places study findings in the context of the conceptual model introduced in Chapter 2 and the existing research literature.

Conceptual Model Revisited

As shown in the conceptual model in Chapter 3 (Figure 1), adapted from Paul Sabatier's Advocacy Coalition Framework (ACF) and John Kingdon's Multiple Streams model,

policy development and implementation are influenced by a number of factors. ACF assumes that there are some relatively stable parameters (i.e., resource distribution and the attributes of the problem area), events external to the policy subsystem (i.e., changes in public opinion and socioeconomic conditions), short-term constraints and resources of subsystem actors, long term coalition opportunity factors (i.e., degree of consensus needed for major policy change and openness of the political system), and the policy subsystem (Weible et al., 2011; Weible, Sabatier, & McQueen, 2009). In the Multiple Streams model, three streams lead to policy development: the problem, policy, and political streams (Kingdon, 2003). These streams merge, with the efforts of policy entrepreneurs, to create a policy window where bills can be placed on the policy agenda.

Interview results from both cases support and build upon some of these factors influencing policy development and implementation. For example, having a strong legislator, or a policy entrepreneur, whose focus was on racial and ethnic health disparities bills and who was able to garner legislative support, contributed to the passage of health disparities bills. The policy subsystem was also influential in policy development and implementation. The subsystem included the broader social, economic, and political environments. Interview results also show that policy understanding among implementers was also an influence in policy implementation. One new element to work into the conceptual model suggested by study results is that personal attributes of implementers, such as past experiences and training, influence policy implementation. These factors will be further discussed below.

Data and Information in the Policy Process

This research did not illuminate much in the way of the politics of the development of the policy creating the OMHs; however, the results did include factors related to successful health disparities policy passage generally and increased awareness of racial and ethnic health disparities among communities and legislators. Interviewees discussed the use of data and other information during the policymaking process, such as using data to illustrate the nature and extent of racial and ethnic health disparities in legislators' districts, for example. As previous research shows, data are one of the types of information that shapes policymakers' understanding of a policy problem and may help them select relevant and appropriate policy responses (Brownson, Baker, Leet, Gillespie, & True, 2010; Radaelli, 1995).

While it is clear that data play a strong role in policy development, it is also clear that there is a need for improved public health and health disparities data quality and availability for use in policy development (Bierman, Lurie, Collins, & Eisenberg, 2002; Petticrew, Whitehead, Macintyre, Graham, & Egan, 2004). As discussed above, Aim 1 findings suggest that data collection and dissemination is a growing focus of state health disparities legislation. Because data are used to make public health policy decisions, such as which racial and ethnic health disparities state OMHs and local communities should target, policymakers and public health administrators should continue to propose legislation or regulations supporting health data collection by race and ethnicity.

Framing and Discourse

Policy problems are not issues that simply exist “out there;” social problems must be constructed and perceived as problems that require policy action (Kingdon, 2003; Stone, 2006). The way that policy problems are framed can impact the probability of legislative success and how the policy is ultimately implemented. Although framing of racial and ethnic health disparities within the policymaking process was not commonly discussed across both states, it is important to note the role that framing plays in policy development.

Racial and ethnic health disparities are generally understood within public health as differences in health status or outcomes among different racial and ethnic groups that are often unfair and unjust (Braveman, 2006). Interviewees in both states gave their perceptions of the nature of racial and ethnic health disparities; while all responses shared this basic understanding of racial and ethnic health disparities, there were some differences in how these disparities were defined. For example, consistent with current literature, some interviewees in both states framed racial and ethnic health disparities in terms of health care, while others focused on differences in broader health outcomes. Interview results emphasize the importance of a shared understanding of health disparities for framing and communication in the policy development and implementation processes. While it is clear that there are different understandings and definitions of racial and ethnic health disparities (Adler & Rehkopf, 2008; Braveman, 2014; Braveman & Gruskin, 2003), creating and using a common understanding of what racial and ethnic

health disparities are is important for both policy development and implementation of health disparities policies and other initiatives. A shared understanding and clear definition of what these health disparities are and their causes can focus legislative efforts on the concepts at the heart of racial and ethnic health disparities instead of diverting resources from intended results (Braveman, 2014). In addition, a shared understanding and definition can also support making the case for health disparities legislation, and facilitate tracking outcomes of advocacy efforts.

Understanding how health disparities and minority health are discussed and conceptualized is also important due to possible shifts in language use and framing. Interview data suggested that race-specific approaches to health disparities legislation and infrastructure, such as OMHs, might be approaching a turning point. Some of the interviewees talked about the movement towards framing racial and ethnic health disparities and minority health in terms of health equity, for example. They discussed that using the health equity frame could attract more legislative support because of the inclusivity inherent in the concept of health equity and less explicit use of race and ethnicity in the discourse. Depending on the personal values and frames that legislators have, using the health equity lens could increase support for improving the health of racial and ethnic minority populations, as well as other vulnerable populations.

Similarly, the use of “health equity” is increasingly favored over the use of “health disparities” in public health research and advocacy, as shown in the literature (Braveman, 2014). This trend can also be seen among state OMHs; some offices have elected to

change their names to include an emphasis on multicultural health (i.e., Wyoming and Connecticut), health equity (i.e., Ohio, California and Virginia), or equity and inclusion (i.e., Oregon) rather than solely minority health or health disparities. Although the use of “health equity” may be increasing in popularity, as noted above, a clear definition of health equity is needed to ensure that resources are directed to the problems related to health disparities advocates and public health practitioners intend to address (Braveman, 2014).

Previous researchers have suggested that it may be time to abandon race as a variable in public health research in favor of class-based or social determinants of health-based approaches (Buehler, 1999). Scholars have noted that the changing political landscape can impact policies aiming to achieve racial equity, particularly focusing on an increase in conservatism coupled with ideology championing limited government, individual responsibility, and color-blind policy approaches (Cashin, 2014). Study results show that race continues to be a focus in state health disparities legislation and may continue to be in the near future, but could face some challenges as a race-neutral approach to policymaking gains momentum. To maintain support for minority health and eliminating racial and ethnic health disparities, advocates and scholars may need to embrace and adopt a different language when it comes to minority health. However, one challenge of a race-neutral approach would be how to address disparities impacting different racial and ethnic groups, especially as the U.S. moves towards a majority-minority population (U.S. Census, 2012). This is something policymakers and advocates should be aware of as they consider race-based and race-neutral approaches to addressing racial and ethnic health

disparities. Focusing on approaches targeting the social determinants of health may be a way to continue to tackle racial and ethnic health disparities in a race-neutral environment.

Internal and External Environments

Both internal and external environments can influence the decision of a state legislature to pass an introduced bill, if a governor signs a bill passed by the state legislature, or if the governor chooses to exercise their veto power. Internal environment refers to characteristics of the state, such as the state's demographics, economic conditions, or political characteristics, whereas the external environment includes characteristics of the environment outside of the state, such as the political climate of the federal government or broader social and economic conditions. Indeed, interview results suggest that when it comes to policy development and implementation, the political and social environments influence a bill's chances of passing and, once passed, how that bill is implemented.

Internal and external environments may not only influence if a bill successfully passes or the number of bills introduced, but also what topics those bills cover. Policy development can be influenced by several factors, including the burden of disease and particular health needs in the state; the types of populations residing in the state; political and economic conditions of the state; and personal interest of sponsoring legislators and advocates, among other factors in the state. Given that racial and ethnic health disparities are

influenced by a number of social and economic factors, legislation targeting these health disparities may reflect those influences.

As reflected by these results, and in previous literature, legislative support, including policy entrepreneurs, interest groups and other coalitions, and advocates, is necessary to successfully pass proposed policies (Kingdon, 2003). Political ideologies, the external economic and social environments, and policymakers' understanding of the problem and appropriate policy solutions influence this support (Weible et al., 2011; Weible et al., 2009). One interviewee highlighted that understanding the structure and rules of the policymaking process is also key to successfully introducing and passing legislation. Having this knowledge requires that advocates and community partners, including lay people interested in eliminating racial and ethnic health disparities, understand the policymaking process and how they can advocate within the process. Often, community members are unaware of how they can advocate in the policymaking process, leading to few lay people participating in creating legislation. As such, creating infrastructure for advocacy in both state and local legislative bodies at the local level can be a first step towards encouraging more community members to participate in the public policy process.

Policy Implementation

Results from Aims 2 and 3 provide evidence about what factors influence policy implementation. As previously discussed, policy implementation is influenced by a

variety of factors, including resources such as funding and human resources, the broader political and social environments, and qualities of those responsible for implementation such as perception and past experiences. There are also challenges in implementing public policies; for example, as Durlak and DuPre argue, policy implementation is stymied by a lack of funding and other resources (2008).

Appropriations for health disparities activities and infrastructure were a common policy approach states took to address racial and ethnic health disparities. Understanding funding is helpful to not only understanding legislative commitment to eliminating racial and ethnic health disparities, but also shaping our understanding of how and why policy implementation occurred as it did. As interviewees discussed, a lack of funding to support implementation activities can limit policy implementation, including the extent of communities and populations reached, activities conducted, and the impact of those activities. The impact of funding on successful implementation is not new; previous studies have cited a lack of funding and other resources as a factor challenging policy implementation (McLaughlin, 1987). A lack of resources and capacity, particularly funding, were described by interviewees as common challenges facing state OMHs, and is a challenge for state public health agencies generally, especially as states grapple with unfavorable economic environments and limited public health budgets (Jarris, 2012). Because funding both facilitates and limits office implementation, as interviewees suggested, policymakers should ensure that OMHs have both dedicated and diverse funding streams, including, but not limited to, committed state funds.

Policy Design

Study findings suggest that implementation experiences and outputs begin at policy development and how the policy is initially designed. Previous research supports this finding, suggesting that implementation outcomes can be impacted and improved by policy design and that the design of a policy shapes how the policy is implemented (Goggin, 1987). MD interviewees tended to discuss the implementation of the Office in context of the legislation creating the Office, while FL interviewees framed their perceptions of implementation from their own lenses or experiences. This may be because the statute creating the MD Office included detailed mandates that have guided the implementation of the state Office whereas the FL legislation lacked any clear or detailed mandates for implementation.

However, policy design isn't completely protective, meaning that implementation can stray from even carefully designed and detailed statutes (May, 1991). Given that, there are factors beyond policy design and policy understanding that influence implementation to note. Interviewees identified factors including external economic environments, public opinion, and shifts in need as impacting implementation. For example, although the MD Office was created through legislation that is detailed in its mandates, the Office was challenged with funding changes due to the external economic environment, similar to the FL OMH. Although policy design does not completely prevent implementation challenges, policymakers should consider designing OMH and health disparities policies

that provide a basic framework and guidance for implementation, such as expected duties.

Federal Connections and Influence on State Policy Development and Implementation

The federal government has a history of taking an interest in eliminating racial and ethnic health disparities (Moy & Freeman, 2014). The *Heckler Report*, for example, set the stage for recent approaches to eliminating racial and ethnic health disparities at both the federal and state levels by highlighting persistent disparities in health outcomes between Blacks and Whites and providing several policy recommendations (Centers for Disease Control and Prevention, 1986). Similarly, the federal government is a source of national racial and ethnic health disparities data that are often used by public health practitioners, advocates, and researchers at the state level (Hynes, 2012).

Previous research has shown that one factor in state policy development and implementation is the federal government. Initiatives at the federal level to eliminate racial and ethnic health disparities can influence the policy directions state legislatures decide to take. Trends on which the health disparities bill topics focused on could be partially due to changes in federal initiatives, including appropriations, strategic plans, research support, or published reports. The *Heckler Report*, for example, included suggestions for initiatives to eliminate racial and ethnic health disparities, including the creation of dedicated infrastructure at the state level for improving minority health and health disparities. *Healthy People*, a 10-year federal plan providing national objectives to

improve the health of Americans, is one example of a federal initiative that influences state health policy. *Healthy People 2000* was the first of the Healthy People plans that focused on health disparities as an overarching objective, calling for the reduction of health disparities nationwide. *Healthy People 2010* called for the elimination of health disparities, and *Healthy People 2020* evolved beyond health disparities elimination to the achievement of health equity. These federal initiatives have influenced state population health planning efforts, such as the alignment of state and local health priorities with national objectives in the design of state health improvement plans, community health assessments, and other planning models (Green & Fielding, 2011; Oberle, Baker, & Magenheimer, 1994). The Affordable Care Act (ACA) also included provisions towards eliminating racial and ethnic health disparities, such as data collection requirements and the creation of federal OMHs at the Food and Drug Administration and Centers for Medicare and Medicaid Services, among others (Koh, Graham, & Glied, 2011).

The National Partnership for Action (NPA) was designed by the U.S. Department of Health and Human Services (HHS) in 2010 to provide a comprehensive, community-based national agenda to eliminate health disparities and achieve health equity. One result of the NPA was the creation of the National Stakeholder Strategy for Achieving Health Equity, which provides guidance to advocates, public health administrators, and legislators towards eliminating health disparities through partnerships. Another result of the NPA was the HHS Action Plan to Reduce Racial and Ethnic Health Disparities. The previous Secretary of HHS, Kathleen Sebelius, also focused on health disparities in her priorities, such as achieving health equity, ensuring access to quality, culturally

competent care for vulnerable populations, and improving health disparities data collection and measurement (U.S. Department of Health and Human Services, n.d.).

The National Prevention Council, comprised of 20 federal departments, agencies, and Offices, created the National Prevention Strategy and provides annual status reports related to the strategy. The Council's focus includes providing technical assistance to non-health agencies and organizations focused on understanding the health impacts of their practices and policies, which includes equity considerations (Rigby, 2011). Health disparities and health equity are also a focus of the Council. For example, in the 2014 status report, the Council reported on various health disparities and health equity activities conducted by organizations and agencies across the U.S. (National Prevention Council, 2014).

Aspects of these federal plans and initiatives are present in state legislative actions to eliminate racial and ethnic health disparities, such as an emphasis on data collection and cultural competence. For example, Aim 1 results show that one federal initiative that may have influenced state health disparities legislation is the National Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS) standards for cultural competency (McDonough, 2004). The federal Office of Minority Health first developed CLAS standards in 2000 and developed an initiative to update the standards in 2010 (U.S. Office of Minority Health, n.d.). Some states have focused on cultural competency and linguistic services before the development of CLAS standards; however, as Aim 1 results suggest, there is evidence that the development of the federal CLAS

standards have prompted other states to adopt methods to improve cultural competency within health and health care organizations. IL S.B. 545 2007, which was successfully passed, called for the development of the Culturally Competent Health Care Demonstration Program, and referenced national standards for cultural competence in health care in the bill text. Other states addressing cultural competency have taken a similar approach.

Disease-specific bills in state legislatures also reflect federal initiatives. At the federal level, the Department of Health and Human Services has indicated a focus on specific diseases to reduce and eliminate racial and ethnic health disparities. For example, eliminating racial and ethnic health disparities is a focal point in the “Secretary’s Strategic Initiatives.” (U.S. Department of Health and Human Services, n.d.) A number of disease-specific bills from state legislatures focused on the same diseases highlighted in federal plans and initiatives, especially HIV/AIDS, infant mortality, and cancer (U.S. Department of Health and Humans Services, 2011).

Study results suggest that there may be patterns in proposed and enacted state legislation related to racial and ethnic health disparities and federal initiatives. Previous research has explored horizontal policy diffusion, such as state-state policy learning and adoption, and also examined bottom-up policy diffusion, such as state-to-federal policy influence (Daley & Garand, 2005). However, the area of federal-to-state policy influence in public health, particularly for racial and ethnic health disparities, is largely unexamined. Additionally, federal-to-state policy influence also tends to focus on legislation and the

passage of laws, but states can be influenced to take legislative action in ways other than the passage of federal laws, such as executive orders, hearings, research studies, and strategic plans. As devolution continues from federal to state-level policy innovation, more opportunities for states to lead in eliminating racial and ethnic health disparities through legislation may emerge (Trivedi, Gibbs, Nsiah-Jefferson, Ayanian, & Prothrow-Stith, 2005).

The federal government is influential not only for state health disparities policy development, but also the implementation of state OMHs. Interviewees discussed the federal government mainly in the context of OMH funding. Both state OMHs received federal funds that complemented state funds for implementation of the OMH and its grant programs. These funds provided direction for which programs the OMH supports (e.g., the grant programs), as well as support OMH infrastructure, including the office's human resources. Although interviewees discussed their perceptions of their office's relationship with the federal government, given the continued focus of health disparities and health equity at the federal level, future research should continue to explore the influence of the federal government on state OMH implementation, programming, and impacts.

While federal initiatives have influenced strategies states have adopted towards eliminating racial and ethnic health disparities, states can also influence federal initiatives. Study results could be used to identify promising practices that could be scaled nationally, including the creation of new national initiatives that could support state innovation in health disparities policymaking. However, policy impacts of these

results are not limited to the federal government. States often learn from each other, and study results could support state-to-state policy innovation. States act as laboratories of innovation because of the structure and nature of state government (Gray, 1973); compared to the federal government, state governments are more responsive to statewide and local needs and are able to experiment with different policy approaches more easily. Emerging trends in research and funding opportunities may translate into future policy approaches; as such, public health practitioners, researchers, and advocates should focus on translating emerging research on eliminating racial and ethnic health disparities into state legislation.

HEALTH DISPARITIES LEGISLATION AND IMPLEMENTATION: CONTRIBUTIONS TO THE LITERATURE

States have used their legislative powers to address the elimination of racial and ethnic health disparities. The Ladenheim and Groman study provided evidence on how states were using their legislative powers to address racial and ethnic health disparities (2006). While the present study does not examine all legislation impacting health disparities, the results build on the limited literature related to racial and ethnic health disparities policies and legislation, and provide an updated understanding of how states have attempted to use legislation to address racial and ethnic health disparities between 2002 and 2011. These data also provide a foundation for future research and policy development. This section describes how study results build on previous literature related to minority health and health disparities infrastructure, appropriations, disease-specific state legislation,

race-based legislative approaches, and presents some gaps in state legislative approaches to racial and ethnic health disparities.

Infrastructure

Similar to the findings from the Ladenheim and Groman study, and other research focusing on steps states can take to address racial and ethnic health disparities, results from this study show that states use legislation to create infrastructure specific to racial and ethnic health disparities and minority health. These results are important to consider in context of the public health literature, especially because the state of public health infrastructure is a concern within the public health and administration fields (Baker Jr. et al., 2005; Tilson & Berkowitz, 2006). The public health system, including state OMHs, has the power and jurisdiction to create laws and regulations that shape public health and health disparities activities.

Appropriations

Findings from the Ladenheim and Groman study show that states used appropriations as a policy strategy towards eliminating racial and ethnic health disparities. Results from the current study suggest that states have continued to provide health disparities appropriations through legislation. This type of legislation could signal a commitment to positive implementation by dedicating specific funds towards health disparities elimination and possibly preventing the reallocation of funds, or at least making it somewhat challenging to reallocate funds away from health disparities (McLaughlin,

1987). Appropriations that could be used for policy implementation are significant given that a lack of financial and other resources is a common challenge in policy implementation. That said, not every mandate as directed in state legislation requires funding, such as legislation providing enabling powers to local government agencies, which provides powers for an action but might not require a particular act (Shaffer, 1995).

Focus on Diseases

Twenty-five percent (n=152) of identified bills targeted a single specific disease. The most common disease-specific bill targeted HIV/AIDS. This finding is consistent with the results of the Ladenheim and Groman study (2006). While some bills included language indicating a legislative intent to target a wide range of diseases or conditions where racial and ethnic disparities are common, the focus of this analysis was on bills targeting one specific disease. Study findings revealed no bills targeting only heart disease, obesity, and diabetes. These health conditions were not part of single disease-specific bills, but were mentioned them in combination with each other, rather than alone. These diseases were also included in the full text of both proposed and passed state legislation as a justification for proposing the bill, such as highlighting the racial and ethnic differences in disease rates, rather than as a directive to focus on these particular diseases in general.

State legislation targeting specific diseases included mandates or suggestions for various approaches to addressing health disparities. Some proposed state legislation simply recognized that a racial and ethnic health disparity existed among those with a specific disease. Other proposed state legislation directed organizations, such as local health departments and community-based organizations, to conduct outreach and education activities to inform the community about the disease or to improve disease management. Approximately a third of the disease-specific bills also included some kind of funding support or appropriations towards addressing disparities among those with a specific disease, including activities focused on HIV/AIDS, behavioral health, infant mortality, lupus, cervical and breast cancer, prostate cancer, and mental health.

Overall, disease-specific bills were the third most common topic targeted in state legislation focused on racial and ethnic health disparities in this study. The commonality of disease-specific bills could reflect a perspective about the causes of racial and ethnic health disparities and what's perceived as appropriate responses to tackling the issue. Focusing on a specific disease could signal that targeting the diseases with the highest disparities, or impacting a certain racial or ethnic group, is preferred over taking a more comprehensive approach to state legislation that could impact more than one disease.

OMHs also adopted a disease-based focus in their implementation. This approach was particularly evident in the grant-making models of both state OMHs. For example, Minority Outreach and Technical Assistance (MOTA) grants in MD first focused on tobacco and cancer disparities, but then expanded to include other diseases such as

cardiovascular disease and infant mortality. The FL OMH grant-making model, Closing the Gap (CTG), adopted a similar approach. This approach may have occurred because taking a disease-specific approach is a way to garner political support; policymakers may be more likely to support funding and encourage a disease-based approach because it may be easier to comprehend and explain to constituents, rather than focusing on directing resources to address the social determinants of health. Similarly, health disparities are sometimes framed as differences in health outcomes, which often focus on diseases. Given this framing and understanding of health disparities, it is logical to expect proposed solutions to health disparities to focus on diseases.

Looking at introduced and passed disease-specific bills along with how interviewees described the roles of their respective state OMHs and related outputs, suggests that the disease-specific approach to racial and ethnic health disparities will continue. Although this approach may target specific diseases, future directions within this approach may have impacts beyond the specific disease, especially if a social determinants of health lens is used within disease-specific approaches. Both grant-making models in the MD and FL Offices targeted particular diseases that were shown, through data, to have a disproportionate burden on minority populations. However, within the grant-making model, grantees were required or highly encouraged to approach these diseases through collaboration, coalitions, and community-based approaches that could incorporate partners from non-health specific organizations.

Race-Based Legislation

States have continued to introduce and pass race-specific health disparities bills. State health disparities bills targeted some racial and ethnic groups, particularly Native American, African American, and Hispanic populations. Ladenheim and Groman included statutes and bills from one legislative year (2001-2002) targeting some racial and ethnic groups, but also found a lack of legislation specifically addressing Hispanic populations (2006). Since the publication of their study, that trend has started to change. Results from the present study show that since the Ladenheim and Groman study, states have used the legislative process to target the health of Hispanic populations. This increase in bills targeting Hispanics could be due to the significant growth of the U.S. Hispanic population since the early 2000s (U.S. Census, 2011), which was the end of the time period included in the Ladenheim and Groman study.

Proposed state legislation specifically targeting the Hispanic population was found in Connecticut, Florida, Illinois, New York, Pennsylvania, and Texas. Bills that passed targeting the Hispanic population were found in Illinois and New York. Bills specifically focusing on Hispanic populations had the second highest passage rate out of all race-specific bills (57.7 %). Despite being the fastest growing demographic population group in the U.S. (U.S. Census, 2011), race-specific bills focused on the Hispanic population were third in frequency, following those focused on American Indian/Alaskan Natives and African Americans. Although bills specifically focused on the Hispanic population only passed in two states during the study period, this trend is still a significant finding.

Previous research found a lack in Hispanic-specific health disparities bills (Ladenheim and Groman, 2006), and findings from this study suggest that this focus within health disparities policy may be an emerging focus in state legislation as U.S. demographics shift, along with health trends associated with those demographic changes.

Some race-specific legislation proposed by states during the study's time period also focused on a particular disease. This finding could be because data show that some racial and ethnic groups are more likely to develop a particular disease than others. For example, three of the HIV/AIDS bills targeted African Americans, Hispanics, and Haitians. On the other hand, while some diseases, such as sickle cell, are more likely to affect African Americans, proposed legislation targeting sickle cell was not specific to African American populations. This approach focused on targeting multiple racial and ethnic groups in disease-specific legislation could have positive impacts, such as helping raise awareness of the disease among a variety of populations not traditionally associated with the specific disease.

Developing the Public Health Workforce to Eliminate Health Disparities and Improve Cultural Competency

Similar to the Ladenheim and Groman study, results from this study show that states have continued to propose and enact legislation related to increasing diversity in the public health workforce and opportunities to improve cultural competency among public health and health care practitioners. For example, NJ S.B. 144 2005, which was successfully

passed, requires physician cultural competency training as a condition of licensure. Another successful bill was IL S.B. 1945 2011, which created the State Healthcare Workforce Council, whose work focuses on cultural competency and minority participation in health professions education to improve the diversity of the health care workforce. Cultural competency will likely continue to be a focus in state racial and ethnic health disparities legislation, likely due to demographic changes and subsequent health care and public health needs, as well as a continued federal focus on cultural competency training and standards.

As mentioned above, the U.S. is poised to become a majority-minority nation by 2050 (U.S. Census, 2012); however, the composition of the public health and health care workforces do not reflect these demographic trends. Thus, the nation faces emerging questions related to the public health and health care workforces, as previous researchers have posed (Cohen, Gabriel, & Terrell, 2002; LaVeist & Pierre, 2014). Such questions include: How can we develop a public health workforce that is representative of the nation? What core competencies are needed from the public health and health care workforces to eliminate health disparities in the U.S.? How can we recruit and retain public health and health care professionals to practice in underserved areas?

There is increased attention to understanding and redesigning the composition of the public health workforce among scholars and practitioners to answer such questions. For example, the November 2013 issue of *Health Affairs* was dedicated to redesigning the health care workforce, focusing on topics such as building a health care workforce for the

future. The Institute of Medicine has devoted multiple reports to educating public health and health care professionals, including the report *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce*, focusing on the benefits of racial and ethnic diversity and calling for concerted efforts to diversify the public health workforce (2004).

Results from interviewee data suggest that there are opportunities to connect partners associated with the state offices and to impact the broader public health workforce. For example, there may be opportunities to increase the public health workforce focused on racial and ethnic health disparities through partnerships with state OMHs and their grantees, who tend to use community health workers or youth to achieve their objectives. The public health and health disparities pipeline model targeting youth and undergraduate students is already in use among community-academic partnerships (Glover et al., 2009; Rashied-Henry et al., 2012; Smith, Nsiah-Kumi, Jones, & Pamies, 2009). This type of pipeline should be expanded to include public organizations, such as OMHs, and should also be considered when developing diversity initiatives and training related to health disparities in public health (Cené, Peek, Jacobs, & Horowitz, 2010).

Gaps in State Legislation and Policy Implications

Study results suggest that states have taken a rich variety of legislative approaches to eliminate racial and ethnic health disparities. These health disparities are the result of a combination of health and social determinants, such as political and economic factors (Adler & Rehkopf, 2008; Braveman et al., 2011; Koh et al., 2010). As such, legislation

targeting racial and ethnic health disparities should encourage and support a multidisciplinary, intersectoral approach; health departments and the health care system cannot eliminate racial and ethnic health disparities alone. Policy and programmatic approaches will need to target both health and social determinants of health to eliminate racial and ethnic health disparities.

One promising strategy is a Health in All Policies (HiAP) approach to decision-making. This approach directs non-health agencies to adopt systems-wide changes to consider health consequences when designing programs and policies (Gase, Pennotti, & Smith, 2013; Puska, 2007). Conducting Health Impact Assessments (HIAs) of proposed programs, projects, or policies that are not specifically related to health is one way to facilitate that consideration (National Research Council, 2011; Kemm, 2001). Some successful examples of facilitating the HiAP approach through legislation were developed in the California state legislature, such as requiring the State Transportation Commission to acknowledge policies, practices, or projects that have been utilized by metropolitan planning organizations promoting health and health equity (CA A.B. 441 2011) and also encouraging interdepartmental collaboration to emphasize the environmental factors contributing to poor health and inequities when developing policies (CA S.C.R. 47 2011). This approach helps to eliminate racial and ethnic health disparities by targeting the social determinants of health that have been shown to drive racial and ethnic health disparities, such as social class, income, transportation, education, and housing, among others (Marmot, 2005; LaVeist, 2005; Adler & Rehnkopf, 2008).

Although legislation has been used to require the representation of OMHs on task forces and committees, study results indicate an overall lack of legislation facilitating intersectoral approaches to eliminating health disparities. This finding reflects the broader issue of public health and social sector silos that prevent collaboration towards common goals (Hassmiller, 2002). Further examination of the task forces and committees that OMHs were directed to participate in revealed that they tended to be health-related rather than focused on broader social issues. For example, OMH representatives, typically the director, were directed to participate in health literacy, child health, and other health-specific task forces. One of the few examples of a bill that encouraged non-health departments to consider minority health was Florida's 2011 S.B. 862, which requires specified non-health departments, such as the Florida Department of Corrections, to take minority health issues into consideration in its annual planning. Despite the fact that this bill failed to pass and that this was an uncommon study result, Florida's 2011 S.B. 862 provides an example of how to create opportunities to address racial and ethnic health disparities outside of the public health department. Increasing state legislators' awareness of such approaches could facilitate potentially effective intersectoral approaches towards eliminating racial and ethnic health disparities.

Class, race and ethnicity, and health are often correlated in public health research (Kawachi, Daniels, & Robinson, 2005; LaVeist, 2005a). Current public health literature suggests that class, especially concentrated poverty, and neighborhoods may be a more significant factor in racial and ethnic health disparities than race and ethnicity alone (LaVeist, Pollack, Thorpe, Fesahazion, & Gaskin, 2011; Marmot et al., 1991). The

findings from this research were consistent with findings from Ladenheim and Groman (2006) showing that class-based approaches to target racial and ethnic health disparities, outside of Medicaid, are uncommon in health disparities state policymaking. State legislatures may target certain geographic areas within the state with a higher poverty concentration through legislation, but these approaches may outwardly be race- or disease-based rather than clear and specific class-based strategies.

IMPACTS OF STATE OMHS

Policymakers, researchers, and advocates are often interested in the impacts or effects of public policies. While there is previous research on racial and ethnic health disparities policies and programs, this research has not focused on the impacts of state OMHS. This section will discuss study results related to perceived impacts of state OMHS, including impacts on racial and ethnic health disparities and other organizations, particularly through community-based collaboration and partnership.

OMH Implementation and Community Development and Sustainability

Collaborative public management focuses on facilitating, maintaining, and operating in multi-organizational arrangements, meaning that implementation depends on multiple actors (McGuire, 2006). OMHS recognized that although improving minority health and eliminating racial and ethnic health disparities is under their purview, accomplishing these goals requires collaboration with multiple actors at different levels. Implementing public policies often requires collaboration with other stakeholders, including other

government agencies, academia and universities, private organizations, and community-based organizations. For example, the state OMHs in this study partnered with community organizations, local governments, academia, and citizens interested in eliminating racial and ethnic health disparities.

Community-based capacity building is a way to approach eliminating racial and ethnic health disparities and creating health equity (Griffith et al., 2010; Israel et al., 2010). One of the roles and impacts of state OMHs is connecting with and sustaining community-based organizations addressing racial and ethnic health disparities. Grant-making models that focus on improving organizational capacity have been used in public health practice to create local changes towards eliminating racial and ethnic health disparities (Baril, Patterson, Boen, Gowler, & Norman, 2011). Through the use of grant requirements and the networks created by state OMHs through grants, education and dissemination events, training, and other initiatives, implementing OMHs can build local capacity to eliminate racial and ethnic health disparities. Some of these capacities include infrastructure-building tasks, such as administrative support needed for budgeting and accounting processes. As study results suggest, this type of grant-making model helps provide tools and resources to local organizations to not only provide programming addressing health disparities in their communities, but also improve the ability of local organizations to collect and analyze data needed for sustainability. Providing these resources and capacity related to data addresses a challenge facing many local government and community-based organizations (Institute of Medicine, 2010).

State OMHs also sustain community efforts towards eliminating racial and ethnic health disparities through partnerships. Community organizations, including nonprofits, academia, and state and local health departments, often work in silos rather than in substantial collaboration, which can lead to duplicative efforts and inefficiencies (Institutes of Medicine, 2008). State OMHs can connect these various organizations by helping them pool resources and avoiding duplication, which in turn could expand their reach and create new approaches to tackling health disparities in their targeted communities through partnerships. Study results also suggest that state OMHs focus on citizen engagement as a strategy for collaboration and partnerships, which is useful for solving problems that require multiple actors and sectors (Cooper, Bryer, & Meek, 2006). Such a collaborative approach, as illustrated by study findings, aligns with recent directions in public and non-profit management focused on collaboration and partnerships (Agranoff & McGuire, 2003).

Partnerships and collaboration can impact community health and the rate of change in systems impacting public health (Roussos & Fawcett, 2000). While partnerships between organizations already focused on community health, or racial and ethnic health disparities, are promoted and supported through OMH implementation, more partnerships are needed between health and non-health organizations, such as those whose work address the social determinants of health. Examples of these organizations focused on the social determinants of health include state and local departments of education, housing, or transportation. Current OMH grant requirements may include the creation of community coalitions, these requirements could be expanded to mandate the inclusion of

non-health organizations, such as representatives from nonprofit and local government agencies focused on education, transportation, housing, and economic development, among others.

Additionally, a collaborative model, such as how interviewees described collaboration in this study, can also be used to further the goals of increasing workforce diversity in public health. As discussed above, the public health workforce does not reflect the population it serves, but state OMHs engage those from the communities they hope to impact. Because of this engagement, questions have emerged related to community engagement and the public health workforce. For example, is the collaboration between local communities and organizations and state OMHs creating enough opportunities to build enough skills and experiences to transfer to jobs to enter the public health workforce? This and related questions should be of interest to policymakers, advocates, and researchers as the health disparities and health equity movement moves forward.

POLICY IMPLEMENTATION AND EVALUATION

Policymakers and advocates are often interested in capturing policy results and impacts, including outcomes from implementation. Previous research has shown that understanding implementation is critical for understanding the effects of public policies (Durlak & DuPre, 2008). Although researchers have provided some guidance as to what successful implementation is, success is not always clearly defined, particularly if goals or desired outcomes were not outlined in the original policy design (Mazmanian &

Sabatier, 1983; Sabatier & Mazmanian, 1978). Thus, it can be unclear how and which impacts or outputs should be monitored for evaluation. Despite this lack of clarity regarding the metrics, it is important to evaluate policy implementation for the purposes of understanding what happened, how it happened, policy outputs and impacts, and to improve management and implementation (Glasgow, Vogt, & Boles, 1999; Sanderson, 2002).

Policy evaluation tends to rely upon quantitative rather than qualitative evidence; however, not all impacts can be quantified. For example, similar to previous research on the impacts of racial and ethnic health disparities programs (Shaw & Butler, 2014), one of the common perceived impacts of state OMHs in this study is increased public awareness and education about racial and ethnic health disparities. Although interviewees acknowledged that measuring increased awareness and education was difficult, they felt that this was one of the most important impacts the OMH has had in the state. A reliance on quantitative evaluation methods could overlook policy impacts, such as this, that are difficult to quantify. Thus, in policy evaluation, qualitative perceptions of the impacts of the policy should be collected and included in the analysis (Bogdan & Taylor, 1990; Patton, 1990). Several examples of public health studies exist that have used qualitative analysis to evaluate public health policies and their implementation (Butterfoss, 2006; Frattaroli & Teret, 2006).

Successful policy evaluation begins with asking the right questions, which some researchers assume to be the question of “Does it work?,” rather than asking about the

process implementers use to make a policy work (Bogdan & Taylor, 1990). Determining the effectiveness of a policy is important, particularly because policymakers and advocates are interested in solving social problems through policy. However, it is not the only question to ask in evaluation, as the answers to that question may not provide the complete picture of policy impacts. Some governments have moved towards a results-based accountability framework to justify policies; as such, there may be an over-reliance on quantitative data to evaluate and support current policies and activities (Moynihan, 2006). However, using qualitative methods for policy evaluation can help answer these and other questions, and answers to those questions can help understand the process of implementation (i.e., process evaluation) and can provide support for the continuation or revision of a current policy.

How implementers understand the policy has an impact on how the policy is implemented (Spillane, Reiser, & Reimer, 2002); in the two cases presented here, how the policy was understood by interviewees shaped their perceptions of the implementation process. For example, a few FL interviewees acknowledged or understood OMH implementation not through the lens of the enabling policy creating the Office, but through the legislation shaping the implementation of the main grant program (CTG). Other study findings provide support for what should be considered when evaluating state OMHs, which will be discussed next.

Evaluating State OMHs

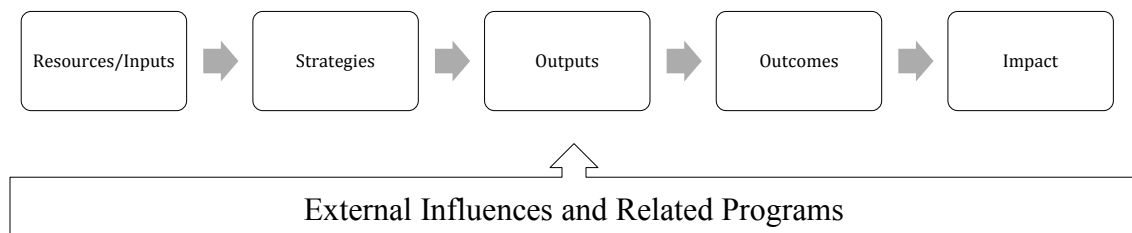
While the FL CTG grant program has been evaluated, neither state Office had been formally evaluated at the time of the interviews. This lack of evaluation of state OMHs is also evident within the public health and public administration literature as there are no peer-reviewed reports focused on evaluation of state OMHs. As federal and state governments continue to emphasize impacts and results of government policies and programs, evaluation of state OMHs could be useful in addressing some of the challenges state OMHs face during implementation, such as building legitimacy and maintaining legislative support. Evaluating state OMHs can also illustrate promising or best practices to address racial and ethnic health disparities, assess progress towards long-term goals, objectives, and mission, and help grantees and OMH partners assess and strengthen program planning efforts (Office of Minority Health, 2008).

The federal OMH developed an evaluation protocol, “An Evaluation Protocol for Systematically Evaluating Efforts to Improve Racial and Ethnic Minority Health, Reduce Health Disparities, and Effect Systems Approaches” (Office of Minority Health, 2008). The purpose of this protocol was to provide guidance for OMH grant applicants/grantees, contractors, other funded partners, and other stakeholders as they design and implement evaluations to determine if results have been achieved (Office of Minority Health, 2008). This guidance includes understanding OMH goals and identifying outputs and impacts, including relevant performance measures that track progress towards those goals (Office of Minority Health, 2008). Glasgow and colleagues also developed principles to guide evaluations of racial and ethnic health disparities interventions (Glasgow, Vogt, & Boles, 1999). While these materials provide useful guidance for evaluation, findings from the

present study contribute to these tools, especially regarding how state OMHs should be evaluated for the purposes of improving implementation, outputs, and impacts.

Evaluations tend to begin with a logic model to understand how the policy or program being evaluated works and should lead to its intended outcomes (McLaughlin & Jordan, 1999). This model typically includes factors related to resources/inputs, strategies, outputs, outcomes, and impact (Figure 4). The logic model may also include factors from external influences and related programs. Based on Aims 2 and 3 study results, there are concepts that should be included for each of these factors in the logic model when considering an evaluation of state OMHs. These concepts, further discussed below, can build upon the foundation for state OMH evaluation set by previous protocols, including the one developed by the federal OMH mentioned above.

Figure 4: Typical Logic Model



(modified from *Funding for Strategic Impact*, TCC Group)

Resources/Inputs

Factors related to resources/inputs should include the enabling legislation creating the state OMH (or the regulation or other guidance shaping the Office if the Office was not created legislatively). A measure related to policy change should also be considered when evaluating state OMHs. Study results show that not all state OMHs are created with clear guidance, but may be operating under guidance that can evolve. For example, the enabling legislation that created the FL OMH, included no details that could shape implementation; however, there were subsequent efforts to influence implementation through proposed legislation to provide mandates for the Office, such as expected duties. Although identifying appropriate indicators for each policy evolution may be challenging, the FL OMH may not be the only office facing this phenomenon; therefore, capturing if the resources/inputs in terms of policy have changed should be considered when designing an evaluation of state OMHs. Other resources/inputs that should be considered include funding, human resources (including state OMH employees and external partners), and any other resources that are available to the office to complete its strategies.

Strategies

Strategies that state OMHs take towards eliminating racial and ethnic health disparities in their states include the roles state OMHs play and the activities they conduct within their roles. While no two state OMHs are alike, results from Aims 2 and 3 suggest that OMHs in different states have similar roles that could be evaluated such as public education, increasing awareness of racial and ethnic health disparities among policymakers and

community members, and building and maintaining partnerships at the state and local levels. State OMHs operate at multiple levels with multiple actors, which influence their implementation outcomes. These actors, such as community-based organizations and academics, should be included in evaluations of state OMHs and should, perhaps, also be evaluated to more fully understand the roles state OMHs play among these actors.

Outputs

Outputs are the results of the strategies or activities that state OMHs have conducted. These outputs should be related to the theorized causal links between state OMH strategies and the outcomes they are trying to achieve. Study results provide evidence that the outputs of state OMHs vary, but there are some general concepts related to outputs that should be captured in evaluations of state OMHs. One output common across state OMHs would be the number of community members reached through various strategies, such as grantee health fairs or health education courses offered. Another output that could be considered when evaluating state OMHs is the number of health disparities-related legislation introduced each year by the state legislature. The number of partnerships formed and/or maintained each year between the Office and external organizations could be another output used to help evaluate state OMHs. Process measures can also be used to measure outputs, such as who delivers programs or initiatives, how often programs are delivered, if programs were implemented with fidelity, how adaptations to program designed changed throughout implementation, and

challenges associated with implementation, among others (Dorner, Howard, Slapac, & Matthews, 2014; Substance Abuse and Mental Health Services Administration, n.d.).

Outcomes

Outcomes include short-term and immediate changes in target population behaviors, including awareness and knowledge. Study findings revealed that a perceived outcome of state OMH implementation included changes in awareness about racial and ethnic health disparities among citizens and legislators. Another outcome included influencing attitudes about racial and ethnic health disparities among program participants. For example, a few interviewees discussed how grant-making activities from the state OMH enabled them to reach and recruit youth participants, who often were not aware or had limited knowledge of health disparities. When evaluating state OMHs, outcomes should capture changes in attitudes and knowledge among policymakers and other people in power, administrators or public servants, those in partner organizations (i.e., grantees), and lay citizens.

Impact

Impact as a category in the logic model refers to long-term impacts of the program or policy being evaluated. Study findings revealed that impacts of state OMHs could be measured in a few ways. One measure of impact would be to explore changes in disease rates or in racial and ethnic health disparities since the creation of the OMH. Another

measure of impact is the perceived impacts of the OMH from implementers, partners, or legislators and changes in local or community-based organizational capacity. The ability to determine these objective and perceived impacts depends on the availability of data. Also, while it may be challenging to measure and track perceived impacts over time, because baseline data may not exist (i.e., lack of baseline measures on legislator awareness of racial and ethnic health disparities), efforts should still be made to collect these important measures.

External Influences and Related Programs

Previous literature and study findings show that external influences can impact policy development and implementation. No two state OMHs are exactly alike and state OMHs operate in different social, economic, and political contexts, which shape their implementation, outputs, outcomes, and impacts. Some OMHs are implemented in states with a long history of using state legislative powers to address racial and ethnic health disparities, whereas in others, racial and ethnic health disparities are an emerging interest among policymakers. As such, these influences should be captured when evaluating state OMHs. Finally, federal influences should also be considered when evaluating OMHs. Findings from this research revealed that federal directions in racial and ethnic health disparities legislation may influence state legislative action. In addition, the federal government may shape state OMH implementation.

FUTURE RESEARCH

Study findings pose interesting questions that should be considered for future research.

One finding from Aim 1 was that out of the 607 bills analyzed, the respective state governor vetoed 7 after they were passed in the state legislature. Future research should explore the reasons for these vetoes, and examine vetoes on both state health policy broadly, and on health disparities legislation in particular.

Appropriation levels were not analyzed for this study, nor in the Ladenheim and Groman study. Understanding how much funding states appropriate for racial and ethnic health disparities programs and infrastructure is important and should be considered for future research.

Evidence from this research suggests that how racial and ethnic health disparities are framed may be evolving due to changes in the broader social and political environments. Additional research should further examine how racial and ethnic health disparities are framed during the policymaking process and the impacts of those frames on legislative success and subsequent implementation.

The federal government will likely continue to influence state approaches towards eliminating racial and ethnic health disparities, particularly on cultural competency and in providing funds to states and local communities to address racial and ethnic health disparities. However, because states are often laboratories of innovation, the federal

government may also be influenced by the approaches states take in legislation targeting racial and ethnic health disparities. Future research should also examine to what extent federal government activities have influenced state legislation on racial and ethnic health disparities, and vice versa.

This study did not examine the population health impacts of the implementation of state OMHs or of the racial and ethnic health disparities legislation introduced and passed by state legislatures. Future research should examine the relationships between health disparities policymaking and state OMHs with public health outcomes, including impacts on racial and ethnic health disparities at local and state levels.

Study results provide evidence that the capacities of communities are being built locally through the implementation of OMHs. This type of collaborative implementation model can have impacts beyond creating and sustaining partnerships. What is not as clear, and should be the focus of future research, is how these capacities are being used outside of the community or local organization. Findings from such research can show the broader public health workforce impacts of OMH collaboration and partnerships.

STUDY STRENGTHS AND LIMITATIONS

There are several strengths of this dissertation research. This study provided a national overview of recent legislative efforts to address racial and ethnic health disparities using multiple methods (legal, quantitative, and qualitative research methods). The methods

used can be replicated in future research to determine if the trends identified from this work have continued, or if new ones emerged. Study results illustrated geographic variation proposed and enacted state bills throughout all 50 states from 2002-2011; to the best of my knowledge, this was the first time a study like this was conducted. This study also covered a decade of proposed and enacted state legislation, allowing for a longitudinal analysis of health disparities legislation. Additionally, the study examined both bills that were introduced but failed to pass and those that were successfully enacted into law were analyzed in this study, allowing for a more complete understanding of state legislation focused on racial and ethnic health disparities to emerge.

This study also captured the process of OMH development and implementation from the perspectives of some of the actors involved with the process, including both the implementers and those at the receiving end of implementation. To the best of my knowledge, no other study has captured or analyzed this experience. The literature on state OMHs in general is quite limited. Although only two states were examined in this study, these states are diverse in terms of income, the characteristics of racial and ethnic minority populations within the state, and political environments, which increase the generalizability of the findings.

Despite the important contributions to the existing knowledge, there were some limitations of this dissertation research that should be noted. The following are some Aim 1 limitations. There may be some limitations associated with the keywords used to identify relevant bills as part of the legal research. For example, each state legislature

operates in a unique demographic and social environment, which may influence how health disparities are framed and addressed in that state. Thus, states that did not introduce at least one health disparities bill may have targeted racial and ethnic health disparities without using specific language that the keywords could have picked up.

Additionally, state policy approaches could fall outside of legislative action, such as regulations developed by the state health department, and this research did not collect information on these non-legislation policy actions since they fell outside of the study's scope. However, it is important to note that state legislation often affects non-legislative action (Ladenheim & Groman, 2006). For example, an administrative agency in the executive branch could promulgate rules and regulations impacting racial and ethnic health disparities using powers granted to the agency through legislation that did not explicitly address racial and ethnic health disparities. Additionally, this study did not examine executive orders promulgated by state governors. Governors can, and have, exercise their executive order power to address racial and ethnic health disparities; but governor-issued executive orders might only remain in effect for the duration of their term and may not have as much of a long-term impact as legislation. The purpose of this research was to specifically examine actions taken by state legislatures concerning racial and ethnic health disparities; thus, this limitation minimally affected the study results.

The study only focused on the 50 U.S. states and did not include U.S. territories or the District of Columbia; therefore, these findings might not be generalizable to these jurisdictions not included in the analysis. Medicaid bills were not analyzed as a part of

this study, which limits the understanding of all efforts state legislatures took towards eliminating racial and ethnic health disparities. Although the exclusion of Medicaid bills may have resulted in missing some ancillary bills, this limitation does not affect study results.

The analysis of these laws did not include a rating of the strength of the legislation, such as the language used within the bill text. Data analysis also did not examine the impacts of these bills, including if the legislation that passed affected health outcomes and health disparities. However, these limitations do not bias the study findings because the purpose of the study was to characterize state legislative approaches rather than analyze the impacts or strengths of those approaches. Finally, not all state legislatures meet every year; as such, legislators in those states have fewer opportunities to introduce health disparities bills, which can skew the appearance of commitment to eliminating racial and ethnic health disparities through state legislation.

Limitations for Aims 2 and 3 relate to the qualitative data collection. These limitations refer to the key concepts concerning validity and reliability in qualitative research, including sampling, interpretation/confirmability, transferability, and credibility. The sampling method was purposive and relied on both public information and snowballing, which could bias the sample. For example, there may be some people who were involved in the development or implementation of state OMHs whose information may not be public or unavailable to other study participants. This may bias the study results towards people who have a public presence or who have maintained contact with those who are

currently involved in racial and ethnic health disparities work in these two case states.

The small sample size used to collect data for Aims 2 and 3 may also be considered a limitation. It is likely that sample size had a minimal effect on the study results because data were collected until saturation; that is, potential participants were sought and interviewed until no new information was presented from the participants.

Additionally, while there were attempts to include current FL state OMH employees in the interview process, FL perspectives were limited to former FL OMH administrators. Since current employees were not included, the data may have been affected by recall bias, as some of these former employees last worked at the FL OMH over several years ago. This bias was minimized by triangulating their perspectives with an analysis of documents provided by the FL OMH and through its website. Triangulation was also used to address possible participant biases among MD interviewees. For example, although MD interviewees in general were less susceptible to recall bias, documents were used to triangulate interview data that referred to the early history of the Office.

Qualitative research data are subject to researcher interpretations and are vulnerable to the frames and worldviews a researcher brings to the study. The researcher's worldviews could introduce confirmation bias and influence study results towards how they think about or perceive the phenomenon under study. Being reflective about data collection and analysis through keeping a research journal minimized this bias. Checking for negative instances of study findings within the interview data was also a method used to ensure confirmability. Relatedly, credibility, or trustworthiness, of the study results could be

vulnerable to the researcher's interpretation. Triangulation was used to minimize biases that could be introduced by the researcher's interpretation of the qualitative data to ensure that the study findings are credible. Interview questions were also pilot tested and reviewed by scholar other than the researcher to ensure that interview questions related to the research aims and were unbiased.

Only two states were used for the cases, which could limit the transferability of study results. While both states had a few similarities that could limit transferability, selecting two states as cases that have political, social, and economic differences minimized this limitation. However, both case states are from the east coast of the U.S., so study findings may not be particularly applicable to mid-western or western states due to regional differences in the political, social, and economic contexts. Additionally, Offices in both states were relatively new compared to Offices created in the 1980s and 1990s; as such, study findings may differ for states that have been in existence longer.

Reliability in research methods refers to the ability to reproduce or replicate the study. Because qualitative research methods are iterative and interpretive, it may be difficult to replicate a study and arrive at the same findings. However, clearly documenting each step of the research method and providing a record of study processes and decisions may minimize this bias. Although a case study database was created for this study to provide a record of the study process and procedures, given the nature of qualitative research, study findings could differ if this study was replicated.

CONCLUSION

Findings from this dissertation research provide a foundation for understanding patterns of state legislation to eliminate racial and ethnic health disparities. State OMHs play a significant role in the effort to eliminate racial and ethnic health disparities, and will likely continue to be an influential factor in the health disparities movement. Findings focused on OMH policy development and implementation provides evidence for the significance of policy design. Although most states have already created their state OMH or related entities, future state legislation addressing state OMHs should focus on creating clear mandates that will support OMH implementation. State OMHs face several challenges, such as funding and political and administrative support; however, a first step towards addressing those challenges could start with clear and comprehensive state policies to improve OMH implementation.

State legislation is just one approach being used to eliminate racial and ethnic health disparities. Creating favorable legislative environments through a variety of topic areas to support the elimination of health disparities is one step towards achieving health equity in the U.S. As the U.S. experiences significant demographic shifts, moving towards a majority-minority country by 2050, building upon previous legislative successes and understanding the health impacts of racial and ethnic health disparities legislation will enable health advocates to address the most pressing health concerns among the growing non-White populations.

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APPENDIX A

KEYWORDS

The complete list of initial search terms is (categories are in bold and are not search terms themselves) (when using search terms to locate relevant text within bills, replace the ! with either “y” or “ities” to complete the word):

General Health

Health w/s disparit!
Minority health
Vulnerable health populations
Health equit!
Health inequit!
Multicultural w/s health
Multiethnic w/s health
Medically underserved w/s minorit!
Minority w/s health care
Health care disparit!
Minority elderly w/s health

Cultural Competency

Cultural competen! w/s health
Culturally compenten! w/s health
Cultural competen! w/s physician
Physician w/s culture
Physician w/s linguistic

Race/Ethnicity-Specific

Black w/s health
African American w/s health
Native American w/s health
Alaskan Native w/s health
American Indian w/s health
Asian w/s health
Hispanic w/s health
Latin! w/s health

Workforce, Education, and Research

Health workforce w/s divers!
Health career w/s minorit!
Health research w/s minorit!

Disease-Specific

Sickle cell w/s minorit!
Cardiovascular disease w/s minorit!
Diabetes w/s minorit!

APPENDIX B

AIM 1 CODEBOOK

The Development and Implementation of State Offices of Minority Health Aim 1 Codebook

<i>Variables</i>
State
FIPS
Citation
Legislative Session
First Sponsor
Pass
Appropriations
Omnibus
Data
Collection/Reporting/Planning
Research Study
Disease-Specific
Specified Disease (text)
Race Specific
Specified Race
Infrastructure
OMH
Task Force/Committee
Representation
Workforce
Cultural Competency
Recognition/Awareness
Notes
LegDem

Variable Name: State

Description: The state in which the bill was introduced using the two-letter state abbreviation

Coding: text

Variable Name: FIPS

Description: Numeric code used to systematically identify states by the National Institutes of Standards and Technology

Coding: numeric

Variable Name: Citation

Description: Standardized method of identifying bills identifying the legislative body and bill number

Coding: text

Variable Name: Legislative Session

Description: The year(s) of the legislative session in which the bill was introduced

Coding: numeric

Variable Name: First Sponsor

Description: Last name of the first sponsor of the bill

Coding: text

Variable Name: Pass

Description: Whether or not the bill was passed into law

Coding: 0 (failed), 1 (passed)

Variable Name: Appropriations

Description: Describes if the bill involves appropriating funds related to racial and ethnic health disparities

Coding: 0 (no), 1 (yes)

Variable Name: Omnibus

Description: Only applicable for appropriations bills; indicates if the appropriations was a part of an omnibus/larger budget bill

Coding: 0 (no), 1 (yes)

Variable Name: Data collection/Reporting/Planning

Description: Describes if the bill involves collecting or reporting on data related to racial and ethnic health disparities or directing planning or programming related to racial and ethnic health disparities

Coding: 0 (no), 1 (yes)

Variable Name: Research Study

Description: Describes if the bill involves directing an organization to conduct a research study on racial and ethnic health disparities; also applies to bills related to including racial and ethnic minorities in public health/medicine research studies

Coding: 0 (no), 1 (yes)

Variable Name: Disease-specific

Description: Describes if the bill targets a specific disease

Coding: 0 (no), 1 (yes)

Variable Name: Disease-specific (text)

Description: Only applicable for disease-specific bills; indicates the specific disease

Coding: text

Variable Name: Race-specific

Description: Describes if the bill targets a specific race or ethnic group

Coding: 0 (no), 1 (yes)

Variable Name: Race-specific (text)

Description: Only applicable for race-specific bills; indicates the specific race or ethnic group

Coding: text

AA: African-American/Black

AIAN: American Indian/Native American/Alaska Native

API: Asian/Pacific Islander

AS: Asian only

HIS: Hispanic/Latino

NH: Native Hawaiian

PI: Pacific Islander only

Variable Name: Infrastructure

Description: Describes if the bill focuses on targeting or creating infrastructure related to racial and ethnic health disparities

Coding: 0 (no), 1 (yes)

Variable Name: OMH

Description: Only applicable if the bill is coded as infrastructure. Describes if the bill focuses on targeting or creating an Office of Minority Health (OMH) or related-entity

Coding: 0 (no), 1 (yes)

Variable Name: Task Force/Committee

Description: Only applicable if the bill is coded as infrastructure. Describes if the bill focuses on targeting or creating a task force, committee, or other non-OMH infrastructure for racial and ethnic health disparities

Coding: 0 (no), 1 (yes)

Variable Name: Representation

Description: Only applicable if the bill is coded as infrastructure. Describes if the bill directs representation of an organization, such as an OMH or related committee, on a task force or other collaborative effort

Coding: 0 (no), 1 (yes)

Variable Name: Workforce

Description: Describes if the bill targets the public health workforce to address racial and ethnic health disparities, including training and diversity

Coding: 0 (no), 1 (yes)

Variable Name: Cultural Competency

Description: Describes if the bill focuses on addressing cultural competency (including linguistics)

Coding: 0 (no), 1 (yes)

Variable Name: Recognition

Description: Describes if the bill recognizes racial and ethnic health disparities without substantial action on racial and ethnic health disparities

Coding: 0 (no), 1 (yes)

Variable Name: Notes

Description: Allows for any notes related to the bill

Coding: Text

Variable Name: LegDem

Description: Describes if the legislature during the legislative session was controlled by Democrats

Coding: 0: Republican controlled

1: Democrat controlled

2: Split legislature

APPENDIX C

INTERVIEW PROTOCOLS

The Development and Implementation of State Offices of Minority Health Key Informant Interview Protocol for Administrators and Partners

Before beginning the interview:

- Introduction of the researcher
- Purpose and overview of the project
- Consent and disclosure statement
- Confirm the amount of time the interviewee has available
- Ask for permission to audio record the interview
- Answer any questions the interviewee has

This protocol serves as a general guide to conducting interviews. Actual follow-up questions may vary

Background information

What is your official job title?

How long have you worked at [name of the Office]?

Tell me about your position as [job title] at [name of the Office]

What are your main duties and responsibilities at [name of the Office]?

How many employees are staffed in the [name of the Office]?

Implementation

What are the main activities that [name of the Office] is involved in?

Who are the target populations of those activities?

What are some of the impacts of those activities?

What are some of the [name of the Office]'s accomplishments?

Tell me about other stakeholders that the [name of Office] partner with.

What are some resources available to [name of the Office]?

Probe, as needed:

Did the state legislature dedicate resources to the [name of the Office] when it was first created? Currently?

What are some difficulties [name of the Office] faces or has faced in the past?

What factors are important for successful implementation of the [name of the Office]'s activities?

Describe the relationship between the [name of the Office] and the state legislature.

How could implementation of the [name of the Office] be improved to achieve its mission?

If the office underwent a name change, ask these questions:

Why was the [name of the Office] changed from [previous name of the Office]?

In your opinion, did that name change impact the mission or activities of the Office?

Problem Understanding

In your opinion, what are health disparities?

In your opinion, what are the main reasons health disparities exist in [the state]?

Policy Understanding

Why do you think the [state legislature, secretary of health, governor, etc.] created the [name of the Office]?

What do you think “success” would look like?

Conclusion

Is there anything you would like to tell me about [either the Office or the policy process] that we haven’t already discussed?

Who else should I talk to learn more about [either the implementation of the Office or the development of health disparities policies]?

Key Informant Interview Protocol for Policymakers and their staff

Before beginning the interview:

- Introduction of the researcher
- Purpose and overview of the project
- Consent and disclosure statement
- Confirm the amount of time the interviewee has available
- Ask for permission to audio record the interview
- Answer any questions the interviewee has

This protocol serves as a general guide to conducting interviews. Actual follow-up questions may vary

Background information for policymakers and staff

How long have you been a [title of the legislative position]?

Policy Process

Tell me about the [health disparities bills the participant sponsored or co-sponsored]

Probe, as needed:

What were your reasons for introducing [or co-sponsoring] [the bill]?

What were some of the strategies that were used to pass [the bill]?

Tell me about any critical moments that occurred during the legislative process before the bill was passed.

How was the issue of health disparities framed during the legislative process?

Probe, as needed:

Was race explicitly discussed during the legislative process?

Were other health disparities, besides race, discussed?

Who were some other stakeholders involved in the efforts to pass the bill?

Problem Understanding

In your opinion, what are health disparities?

In your opinion, why do health disparities exist in [name of state]?

In your opinion, what is the role of the state legislature in addressing health disparities?

Policy Understanding

What did you learn from this process that you would like to share with other stakeholders interested in passing health disparities legislation?

In your opinion, has implementation of [the bill] been successful?

Probe, as needed:

Why [or why not]?

What would success look like?

Could you tell me about other legislative initiatives to address health disparities in [name of state]?

Conclusion

Is there anything you would like to tell me about [either the Office or the policy process] that we haven't already discussed?
Who else should I talk to learn more about [either the implementation of the Office or the development of health disparities policies]?

APPENDIX D

RECRUITING EMAIL

Key Informant Email Recruitment Letter Template

Dear Key Informant,

My name is Jessica Young and I am a PhD Candidate at the Johns Hopkins Bloomberg School of Public Health in the Department of Health Policy and Management. I am completing my dissertation on the development and implementation of state offices of minority health and related entities.

I am gathering information on the policymaking and implementation processes related to the Office of Minority Health in (state), such as how the issue of health disparities became a part of the policy agenda, methods used to pass and enact health disparities legislation. I hope to better understand the policymaking process and factors related to policy implementation to improve upon state efforts to eliminate health disparities. Because of your involvement with (policy development or implementation), I would like to invite you to participate in an interview lasting approximately one hour.

If you are interested in participating in an interview, please reply to this email at your convenience. Please let me know convenient times in the near future for you to participate in this interview. Questions in this interview will relate to your experience in (policy development or implementation) of the Office of Minority Health in (state) such as creating coalitions to support policy passage, activities conducted by the office, and political factors impacting both policy development and implementation.

Results from this study will provide an understanding of the connections between health disparities policymaking and implementation and will be an important contribution to efforts to eliminate health disparities through the state legislative and administration processes. Any time you take out of your schedule to participate in this project is greatly appreciated. If you have any questions, please do not hesitate to contact me at (240) 441-3204 or jlyoung@jhsph.edu.

Thank you!
Sincerely,
Jessica Young

APPENDIX E

INFORMED CONSENT

**The Development and Implementation of State Offices of Minority Health: Key Informant
Interview Consent Document**

PI Name: Keshia M. Pollack, PhD, MPH

Student Investigator: Jessica L. Young, MS

Institution: Johns Hopkins Bloomberg School of Public Health

Study Title: The Development and Implementation of State Offices of Minority Health

IRB No.: 4707

PI Version/Date: Version 3/November 20, 2012

[Greeting]. My name is Jessica Young and I am from the Johns Hopkins School of Public Health and would like to talk to you about a research study on state health disparities legislation and the Office of Minority Health in (state). We are working to understand how health disparities legislation in (state) were developed, how legislation is being implemented, the connection between health disparities policy development and implementation, and the perceived impacts legislation and the Office of Minority Health is having in (state). We ask you to join this study because you participated in the development/implementation of health disparities policy and/or the Office of Minority Health in (state). You do not have to join, it is your choice.

If you say yes, we will ask you to answer questions related to your experience in policy development/implementation of the Office of Minority Health in (state) such as creating coalitions to support policy passage, activities conducted by the office, and political factors impacting both policy development and implementation. It will take approximately one hour to complete the interview.

You may be uncomfortable answering questions. You do not have to answer all the questions and you may stop at any time. Participation in this study is completely voluntary. There is a risk that someone outside the study will see your information. We will do our best to keep your information safe by keeping the audio and transcripts of this interview on a password-protected computer. If we share your information with other researchers, they will use the same protections. You will receive no direct benefit from this study. However, the information provided during this study may benefit your organization and others involved in eliminating health disparities in the future. We will use the information from you to answer our questions about the connections between health disparities policymaking and implementation in (state).

We will not pay you to join this study.

If you agree, your name, position, and organization will be used when quoting you in publications and presentations to disseminate study results. If you do not want your name, position, and/or organization used when quoting you, please let me know now. Do you consent to using your name, position, and/or organization when quoting you?

(Read this only if the participant does not consent to the use of identifying information:

Please be aware that your information may still be identifiable due to your public position or by the description of certain events even if your name, position, or organization are not used when quoting you.)

If you agree to the use of your name, position, and/or organization when quoting you, you will have the opportunity to review your quotes before publication.

You may be contacted in the future with follow-up questions if more information is needed after this interview is complete.

Do you have any questions? You may ask me now, or contact Jessica Young at jlyoung@jhsph.edu or 240-441-3204 about your questions or problems with this study. You may contact the Institutional Review Board which approved this study about any problems or concerns at the Johns Hopkins Bloomberg School of Public Health IRB at irboffice@jhsph.edu or 410-955-3193. The JHSPH IRB may also be contacted toll-free at 1-888-262-3242.
May I begin?

APPENDIX F

CATEGORY/TOPICS OF STATE HEALTH DISPARITIES BILLS AND EXAMPLES, 2002-2011

Category	Example	% of Total Bills (n=607)
Infrastructure		43.2%
OMH	FL S.B. 2728 (2010) Relates to office of minority health; provides legislative intent; provides the duties of the Office of Minority Health; requires the office to submit an annual report to the Governor and Legislature; requires consideration of minority health issues and race in state policy and planning; provides for responsibility and coordination.	24.0% (44.9% of infrastructure bills)
Task Force/Committee	MA S.B. 2239 (2004) Creates a commission on health care disparities	21.9% (41% of infrastructure bills)
Representation	OR H.B. 3389 (2009) Representation of Office of Multicultural Health on the Task Force on Mental Health and Addiction Services for Underserved Populations	7.6% (14.1% of infrastructure bills)
Appropriations	IN H.B. 1789 Appropriations for Minority Epidemiology Resource Center within the Indiana Minority Health Coalition	41.2%
Disease-Specific	NJ A.B. 1875 (2002) Appropriates funds to Office of Multicultural Health for minority prostate cancer activities; same as SB 927	25.0%
Data Collection/Reporting/Planning	WA H.B. 3097 (2006) Addresses health disparities in communities of color and among women by creating an action plan and	16.5%

	statewide policy to include health impact assessments that measure and address other social determinants of health	
Cultural Competency	NY A.B. 9593 (2006) Directs the office of mental health to establish 2 centers of excellence in culturally competent mental health to investigate and disseminate the best practices for the delivery of culturally competent mental health services to underserved populations affected by cultural and linguistic barriers	14.2%
Workforce	IL S.B. 1945 (2011) Creates the State Healthcare Workforce Council; provides that the Council's work shall focus on health care workforce supply and distribution, cultural competence, minority participation in health professions education	11.2%
Recognition/Awareness	MI H.R. 83 (2002) Recognizes National Minority Health Month	9.6%
Race-Specific	NM H.B. 354 (2005) Expanding programs for substance abuse treatment for Native American youth	8.9%
Research Study	IA H.B. 505 (2007) Requires the Department of Public Health to conduct a study regarding the occurrence and treatment of certain diseases and health issues affecting African-Americans; makes an appropriation	4.8%

APPENDIX G

MD OFFICE OF MINORITY HEALTH AND HEALTH DISPARITIES LOGIC MODEL

Health Disparities Intervention Program Logic Model

1. Awareness

Increase awareness of minority adult cardiovascular disease or infant mortality among health organizations and non-health organizations with health impacts.

Promote Cultural Competency and its relationship to improved health outcomes for minorities.

Develop health messages and address concerns that are tailored to the community.

2. Community/Culturally Competent Outreach

Train Community Health Workers and/or Promotoras de Salud.

Provide Outreach and Health Education.

Increase capacity for local health departments.

Increase supply of Health Education materials that are culturally and linguistically appropriate.

3. Leadership

Increase stakeholder knowledge about community-based interventions.

Increase knowledge about State and local health department targeted interventions.

Provide opportunities for new partners to advocate for their communities.

4. Coalitions/Community Task Forces

Increase partnerships between health and social environment organizations.

Provision of support for demonstration of community-based targeted interventions within the jurisdiction.

Enhance local infrastructure and capacity with eventual transition to local sustainability.

5. Data and Research

Collect and report race and ethnic data throughout the jurisdiction.

Identify and share promising practices that target the reduction of health disparities.

Develop a health disparities resource directory of best and promising practices.

(Available at

<http://www.dhmd.state.md.us/mhhd/SitePages/program%20logic%20model.aspx>)

CURRICULUM VITAE

JESSICA LE'VETTE YOUNG

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Birth:
Clinton, Maryland
September 6, 1986

EDUCATION

8/2010-present Ph.D. Candidate, Johns Hopkins Bloomberg School of Public Health,
Department of Health Policy and Management, Health and Public Policy
Track. Advisor: Keshia M. Pollack, Ph.D., M.P.H.

2010 M.S., Health Promotion and Management. American University.

2008 B.A., Political Science. University of Maryland, Baltimore County.

PROFESSIONAL EXPERIENCE

Annie E. Casey Foundation

Campaign for Grade-Level Reading – Washington, DC

Program Associate, Program Development and Support; 10/2014-present

Research, Evaluation, and Learning – Baltimore, MD

Intern/Research Assistant; 02/2014-10/2014

Johns Hopkins Bloomberg School of Public Health – Baltimore, MD

Research Assistant; Winter 2011-Spring 2014

- Dr. Shannon Frattaroli, PI; Winter 2013-Spring 2014
 - Public health advocacy among state public employees
- Dr. Shannon Frattaroli, PI; Spring 2012-Spring 2014
 - Analysis of state residential fire sprinkler legislation and local ordinances
- Beth Resnick, PI; Fall 2011-Spring 2014
 - Setting budgets and priorities in state health agencies with analysis focusing on perceived health care reform impacts and political influences on the budget and priority setting process
- Dr. Keshia Pollack, PI; Winter/Spring 2011
 - Motor vehicle deaths among American Indians and Alaska Natives data analysis

Teaching Assistant; September 2011-Spring 2013

- Health Policy I, Dr. Thomas LaVeist, 2011-2012
- Public Health Practice, Dr. Thomas Burke and Beth Resnick, 2011-2013
- Politics of Health Policy, Dr. Vicente Navarro, 2012-2013
- Public Health and the Law, Jon Vernick, J.D., and Steve Teret, J.D. 2011-2012
- Seminar in Health Disparities, Dr. Thomas LaVeist, Fall 2012

Maryland Department of Health and Mental Hygiene, Office of Population Health Improvement– Baltimore, MD

Research Assistant; May 2011-February 2012

American University – Washington, DC

Graduate Assistant; 01/2009-06/2010

Teaching Assistant; 01/2009-06/2009

Adjunct Faculty; 01/2009 -05/2009

Personal Trainer; 09/2008-05/2009

City Fitness Gym – Washington, DC

Staff/Personal Trainer; 2008-2009

LEADERSHIP

Co-Chair; Johns Hopkins Bloomberg School of Public Health, Student Coordinating Committee, Department of Health Policy and Management (HPM) 06/2011-06/2012

PUBLICATIONS

Young JL, Rutkow L, Pollack K. Review of state legislative approaches to eliminating racial and ethnic health disparities, 2002-2011. *American Journal of Public Health*. Accepted with revisions.

Leider JP, Resnick B, Kass N, Sellers K, **Young J**, Bernert P, Jarris P. Budget and priority-setting criteria at state health agencies in times of austerity: a mixed methods study. *American Journal of Public Health*. 2014; 104(6): 1092-1099.

Leider JP, Resnick B, Sellers K, Kass N, Bernet P, **Young JL**, Jarris P. Setting budgets and priorities at state health agencies. *Journal of Public Health Management and Practice*. June 2013. Published ahead of print.

Jarris PE, Leider JP, Resnick B, Sellers K, **Young JL**. Budgetary decision making during times of scarcity. *Journal of Public Health Management and Practice*. 2012; 18(4):390-392.

Pollack KM, Frattaroli S, **Young JL**, Dana-Sacco G, Gielen AC. Motor vehicle deaths among American Indian and Alaska Native populations. *Epidemiologic Reviews*. 2012; 34(1): 73-88.

Snelling AM, Belson SI, **Young J**. School health reform: investigating the role of teachers. *Journal of Child Nutrition & Management*. Spring 2012; 36(1). Available at <http://www.schoolnutrition.org/Content.aspx?id=17259>.

PRESENTATIONS

Challenges and Opportunities in Developing and Implementing State Offices of Minority Health. American Public Health Association Annual Meeting. New Orleans. November 19, 2014.

Variation in State Statutory and Regulatory Funding Formulas. American Public Health Association Annual Meeting. Boston. November 5, 2013.

State Legislative Approaches to Eliminating Racial/Ethnic Health Disparities. American Public Health Association Annual Meeting. Boston. November 4, 2013.

State Legislative Approaches to Eliminating Racial/Ethnic Health Disparities, 2002-2011. Student Network for Public Health Law Research. September 18, 2013.

Political Institutions and the State Public Health Budget and Priority-Setting Process. Public Health Systems Research Interest Group Meeting. Baltimore. June 26, 2013.

“We’re Trying to Establish Public Health as a Player.” State Public Health Practitioners’ Perceptions of the Impacts of the Affordable Care Act on Setting Budgets and Priorities. Public Health Systems Research Interest Group Meeting. Baltimore. June 26, 2013.

Perceived and Anticipated Impacts of the Affordable Care Act on State Public Health Practice. American Public Health Association Annual Meeting. San Francisco. October 30, 2012.

Weight Training Techniques for Women. Loyola College in Maryland. Sponsored by the Women’s Center, January 21, 2009.

HONORS AND AWARDS

Outstanding Student Service, Department of Health Policy and Management, Johns Hopkins University, 2011-2012

Eddie C. and C. Sylvia Brown Scholar in Community Health, Johns Hopkins University, 2010-present

- Five-year full fellowship to complete doctoral studies in health policy, focusing on health disparities policy development and implementation

Special Opportunity Fellowship, American University, 2008-2010

- Full academic merit fellowship award

Phi Beta Kappa, 2008-present

Public Policy and International Affairs (PPIA) Fellowship, 2007

Sondheim Public Affairs Scholars Program, UMBC, 2004-2008

- Full academic merit scholarship

Outstanding Political Science Scholar, 2008

Robert C. Byrd Scholar, UMBC, 2004-2008

Rhodes Scholarship Nominee, UMBC, 2007

Phi Kappa Phi Honor Society Junior Award, 2006

Golden Key Honor Society, 2006-present

Dean's List, UMBC, 2004-2008

Arthur Ashe Sports Scholar, 2006-2008

President's List, 2006-2008

Semester Academic Honors, UMBC, 2004-2008

ACTIVITIES

UMBC Varsity Soccer Team, 2004-2007

- American East Conference All-Rookie Team, 2004, All-Conference First Team, 2005, America East Conference All-Academic Team, 2005, ESPN/CoSida All-Academic District First Team, 2005, UMBC Soccer Scholarship, fifth all-time leading scorer

MEMBERSHIPS

American Public Health Association, 2011-Present

AcademyHealth, 2012-present

Association for Public Policy Analysis and Management, 2012-2013

American Society of Public Administration, 2012-2013